

Holmbridge Holdings 1852 Limited - Wakefield Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Holmbridge Holdings 1852 Limited

Premises audited: Wakefield Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 3 July 2018 End date: 4 July 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: 19

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

Wakefield Rest Home provides rest home care for up to 20 residents. There were 19 residents on the day of audit.

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

The facility manager is a qualified social worker with significant health management experience and works full time. She has been in the position for five months. She is supported by a health and wellbeing manager (clinical manager) with considerable experience in aged care, who has been in the role for five months. The facility manager and clinical manager are also directors and own the facility.

The service has implemented a quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

Ten of fifteen shortfalls identified as part of the previous provisional audit competed have been addressed. These were around; management, quality systems, corrective actions, incident reporting, interRAI assessments, care plan interventions, referrals for specialised care needs, meal/kitchen management and preventative maintenance.

Further improvements continue to be required around completion of section 31 forms, training for staff, implementation of care, staffing, medication management and condition of linen.

This audit identified an improvement required around fire drills/equipment.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

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.
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There is a business plan with goals for the service that has been regularly reviewed. Wakefield has implemented the quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and is in the process of implementing a training programme. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.
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Care plans are developed by a registered nurse who also has responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate. They are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activity person. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	13	0	0	7	0	0
Criteria	0	40	0	0	7	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. There have been no complaints since the new owner and management team have managed this service. Six residents interviewed advised that they are aware of the complaints procedure. Family members stated that the new management team work with them to ensure they are happy with services.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is a policy to guide staff on the process around open disclosure. The owner/manager and health and wellbeing manager (RN) confirmed family are kept informed. Four relatives interviewed stated they have been notified promptly of any incidents/accidents and any changes to residents' health status. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings have commenced, and they encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.

<p>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>Wakefield Rest Home is co-owned and managed by the on-site manager and the health and wellbeing manager (RN). The service provides care for up to 20 residents, and on the day of audit there were 19 residents; 17 rest home residents and two privately paying boarders.</p> <p>The service has a business plan documented. The service has quality goals, related to addressing the partial attainments from the provisional audit.</p> <p>The facility manager has significant experience in health management, having owned another small rest home in the area. She is a qualified social worker and completed a certificate in management in 2017. The health and wellbeing manager is an experienced registered nurse. She has been working as a clinical manager in the district and is experienced in all aspects of clinical management.</p> <p>The managers have both completed at least eight hours of professional development. Residents, relatives and the GP all commented on the improvements to service and the accessibility of the management team. The qualification of managers and accessibility is an improvement from the previous audit.</p> <p>Residents and family interviewed had no knowledge that any of the residents were boarders. On the day of audit, one the boarders was observed to be actively assisting with activities.</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>	FA	<p>Wakefield Rest Home is establishing a quality and risk programme. An internal audit process is documented where an external consultant undertakes a six-monthly audit through all aspects of service and care delivery, the audit includes an action plan which is added to the quality action plan, reviewed and followed up monthly. The service has documented robust follow-up of all provisional audit actions as well as any actions from internal audits.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (three support workers, one registered nurse, one cook, and one activities person confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support rest home level care.</p> <p>Two-monthly staff/quality meeting minutes sighted (March and May) evidence there is discussion around quality data including health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and corrective actions, this is an improvement from the previous audit. A resident survey has been sent out in June and not all replies have been received yet. Four replies received and sighted so far were all positive. The manager was able to explain the communication process to relatives and residents following collation of the survey.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical</p>

		<p>accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has emergency plans covering all types of emergency situations and staff receive training around this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>The service collects incident and accident data on forms and enters them into an electronic register. The system provides reports monthly, which are discussed at the quality/staff meetings.</p> <p>Six incident forms for June were reviewed. All incident forms reviewed identified a timely RN assessment of the resident and corrective actions to minimise resident risk. However, progress notes did not all identify RN follow up (link 1.3.6.1). Neurological observations had been completed for an unwitnessed fall. This is an improvement from the previous audit. The next of kin had been notified for all required incidents/accidents. The support workers interviewed could discuss the incident reporting process. The health and wellbeing manager collects incident forms, investigates and reviews and implements corrective actions as required. The manager and health and wellbeing manager were not fully aware of the requirement to notify relevant authorities in relation to essential notifications. This is a continued shortfall from the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There are policies in place to support recruitment practices. Five staff files were reviewed (three support workers, one activities person and one cook). All files contained relevant employment documentation including current performance appraisals and completed orientations. Current practising certificates were sighted for the registered nurses. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home level care.</p> <p>Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is an education planner in place that covers compulsory education requirements and training shortfalls from the previous audit and the service is in the process of providing training according to the schedule. Due to the short timeframe since the previous audit, all training has not yet been completed and this is a continued area from improvement.</p> <p>The health and wellbeing manager is interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	<p>PA Moderate</p>	<p>There is policy in place to support safe staffing. The health and wellbeing manager and manager are available on call weekends and after hours as needed. The manager (non-clinical) and the health and wellbeing manager/RN are on duty during the day Monday to Friday.</p>

timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		<p>The staffing has been improved since the previous audit. For 19 residents there are three support workers (two long shifts and one short shift) for the AM, two long shifts for the PM and two long shifts for the night</p> <p>Residents and relatives stated there were adequate staff on duty always and were very happy with the improvement. Staff stated they feel supported by the health and wellbeing manager and manager who respond quickly to after-hour calls.</p> <p>There is not a qualified first aid trained staff member on every shift. First aid training has been booked but not yet delivered. The previous finding around staffing remains an area for improvement.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented on the electronic medication system, however not all had been authorised (signed) by the GP. The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed against the resident's medicine order when new medicines are supplied from the pharmacy.</p> <p>Short-life medications (i.e., eye drops and ointments) were not always dated once opened. The effectiveness of strong analgesia was not always documented. Weekly checks of controlled drug medication were documented, this is an improvement from the previous audit.</p> <p>Education on medication management has occurred with competencies conducted for support workers with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff.</p> <p>A registered nurse was observed administering medications and followed correct procedures. There were no self-medicating residents.</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>There is a kitchen on-site and all food is prepared and cooked on-site. There are two cooks and weekend kitchenhands. All kitchen staff have completed food safety training. The menu has been approved by a dietitian. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. There is an approved food control plan.</p> <p>All food in the freezer and fridge was labelled and dated. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for. Alternative meals can be accommodated if needed. Residents' weights are</p>

		<p>recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</p> <p>The kitchen was clean and well stocked with enough food for three days if needed. There was evidence of pest control and staff reported that there had been no ants. This is an improvement from the previous audit.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Five resident files were reviewed – one resident with anxiety and pain management issues, one with a wound, one with high falls, one with behaviour that challenges, and one new resident. There were no residents with stomas, wandering behaviour or needing a hoist. This aspect of the previous audit was unable to be reviewed. However, for the five care plans reviewed; all care plans reflected the interventions needed for the residents. This is an improvement from the previous audit.</p> <p>The service is in the process of implementing a computer-based care planning system, all the resident care plans and files are now transferred over to the new software, including the five resident files reviewed.</p> <p>Support workers interviewed were well informed regarding resident care needs. Care plans reviewed evidence multidisciplinary involvement in the care of the resident.</p> <p>Short-term care plans are in use for changes in health status and are evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There is evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist, dental health, mental health for older people and dietitian. The care staff advise that the care plans are easy to follow.</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>Care plans sampled were goal orientated. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary. One resident who has been hit by another resident, had no documented follow-up by the RN (the resident was noted to be well with no ill effects).</p> <p>There were two residents with wounds at the time of the audit. There were no residents with pressure injuries. One resident with two chronic leg ulcers, which were being managed by the district nurse and one resident with skin excoriation/scratches. This wound had no wound care plan in place, this is a continued shortfall from the previous audit. Supplies available for wound care were clean and well maintained, this is an improvement from the previous audit.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available as needed.</p> <p>Monitoring records sighted including weights, food and fluids and turning charts were consistently completed. One resident with behaviours that challenge had a short-term care plan in place and a monitoring chart, this is</p>

		<p>an improvement from the previous audit.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is one activities staff member employed who is currently undertaking diversional therapy training. She is responsible for the planning and delivery of the individual and group activities programme with assistance from staff and volunteers. There are organised activities for five days per week.</p> <p>Group activities are provided in the large communal dining room. Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is planned six monthly and a copy of activities available each week is available in the lounge and on noticeboards. Regular entertainers visit the home and there are links to a local school and community to involve them in activities with the residents. There are regular outings into the community.</p> <p>There is a range of activities to meet the recreational preferences and individual abilities of the residents. One-on-one time is spent with residents who choose not to participate in the group programme. Each resident has an individualised activity plan, which is reviewed six monthly. Two monthly resident meetings provide an opportunity for the residents to provide feedback and suggestions on the activity programme.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>The service has its own van for transportation. The DT drives the van and has a current first aid certificate. Residents interviewed described weekly van outings.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if 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>	FA	<p>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Discussion with the health and wellbeing manager identified that the service has access to a wide range of support such as GPs, district nurses and mental health for older people. Discussion with the GP and staff evidenced that current residents were all rest home level care and able to be supported in this setting. This is an improvement from the previous audit.</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>The building holds a current warrant of fitness, which expires 19 April 2019. Testing and tagging of equipment and fire equipment has yet to be undertaken (link 1.4.7.2)</p> <p>The service employs a maintenance person full-time. A sample of hot water temperatures are taken monthly, and these are maintained at (or just below) 45 degrees. The facility's amenities, fixtures, equipment and furniture are appropriate for the level of service contracted. The service has undertaken a series of improvements, such as redecorating, new beds and mattresses, and the garden was in the process of upgrading. There is a planned maintenance programme in place. This is an improvement from the previous audit.</p> <p>The air conditioner and the waste disposal unit in the kitchen have both been mended. Two toilets and two bathrooms have had repairs to walls and floors. This is an improvement from the previous audit. An additional lounge has been created. Relatives and residents were very happy with the new lounge.</p> <p>There is sufficient space to allow residents to move around the facility freely. The hallways are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents' bedrooms throughout the facility have resident's own personal belongings displayed. There is a designated outdoor smoking area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry</p>	PA Moderate	<p>There is a cleaning policy and cleaning schedules in place. Personal protective equipment is available in sluice, cleaning and laundry room. There is a defined clean and dirty area within the laundry with an entry and exit door. There were adequate linen supplies sighted. The cleaning trolley is stored in a locked sluice room when not in use. Safety datasheets are available for cleaning. Staff were observed to be wearing appropriate protective wear when carrying out their duties.</p>

services appropriate to the setting in which the service is being provided.		The service has employed a full-time housekeeper and the service was noted to be very clean and presented well. This is an improvement from the previous audit. Towels remain frayed.
<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>	PA Moderate	The service has an approved fire evacuation plan in place that has been approved by the New Zealand Fire Service. There are emergency and disaster management plans in place to ensure health, civil defence and other emergencies. Six-monthly fire evacuation practices have yet to be implemented with the first one booked next month. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	PA Moderate	The manager was not fully aware of the requirement to notify relevant authorities in relation to essential notifications. One resident had reported to the police that they had been assaulted by a staff member. The service has undertaken a full investigation and the staff member has since left the services employment. The police are aware of the investigation.	The manager and health and wellbeing manager were unaware of the need to document police involvement where there has been alleged assault. A section 31 had not been completed and the contract manager had not been informed.	Ensure sections 31s are completed as per section 31 guidelines and the contract manager informed. 30 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for	PA Moderate	Since purchasing the service, the manager and health and wellbeing manager have scheduled a series of training sessions to provide compulsory training for staff and to ensure that previous shortfalls are addressed with training and support. The service has not completed all training yet due to the short	Not all training required from the previous audit has been provided by the time of this audit. Training is booked and	Continue with training plans for all staff.

service providers to provide safe and effective services to consumers.		timeframe since the purchase of the service. They have completed chemical safety, pain, IC, nutrition, Culture/ Treaty, and medimap. The followed are scheduled, but not yet completed; challenging behaviour, falls, health and safety, and safe handling/ transfers.	scheduled for the service for challenging behaviour, falls, health and safety, and safe handling/ transfers.	60 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Moderate	The manager, the health and wellbeing manager, the maintenance person and some support workers have a current first aid certificate. Not all shifts include a qualified first aider. Training for all staff has been booked.	For one week reviewed; six of seven PM shifts, and one AM shift did not have a qualified first aid person on duty.	Ensure there is a staff member on duty each shift with a current first aid certificate. 60 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	GPs prescribe all medications. Medication charts included the date started for all medications and stopped where relevant. All charts sampled were legible and had been reviewed three-monthly. The effectiveness of analgesia was not always documented, eye drops were not always dated on opening and not all medications on the electronic system had been authorised by the GP (electronic signing).	Three eye drops had not been dated on opening. Seven of ten medication charts had not been authorised by the GP and there was one instance of the effectiveness of strong analgesia not documented.	Ensure that all medications have been authorised (signed by the GP), ensure that eye drops are dated on opening and that the effectiveness of strong analgesia is documented. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and	PA Moderate	The service ensures that all residents receive care and support for all their identified needs as evidenced by resident, family and staff interviews. This is not always documented.	One wound had no documented wound management plan in place. One resident who had been hit by another	Ensure that wounds have a documented wound management plan. Ensure that identified resident

contribute to, meeting the consumers' assessed needs, and desired outcomes.			resident did not have documented follow-up by the RN.	issues have a follow-up assessment documented in the progress notes by the registered nurse. 30 days
Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	PA Moderate	There are policies, and process documented to ensure safe and hygienic services, and these had been implemented. The service is currently in the process of working with an external provider to supply all hotel linen. This has yet to be implemented and frayed towels remain in use.	Resident towels sited were frayed and worn.	Ensure that hotel linen is in good repair. 60 days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Moderate	The service has an approved fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six monthly fire drills have yet to be held. Testing and tagging of equipment and fire equipment has yet to be undertaken.	Six monthly fire drills have yet to be held. Testing and tagging of equipment and fire equipment has yet to be undertaken	Ensure Six monthly fire drills are completed. Ensure testing and tagging of equipment and fire equipment is completed 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.