The Napier District Masonic Trust - Taradale Masonic Residential Home & 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 Q-Audit 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:	The Napier District Masonic Trust
Premises audited:	Taradale Masonic Residential Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 17 July 2018 End date: 18 July 2018

Proposed changes to current services (if any): Dual service beds - 12

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

The Napier District Masonic Trust provides rest home and hospital level care for up to 74 residents. The service is operated by a general manager and managed by a quality and operations manager and a clinical manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family, management, staff and contracted allied health providers and a general practitioner.

In addition to this certification audit a partial provisional audit was undertaken to configure 12 existing beds as dual purpose. The audit team found that the 12 beds assessed are suitable to be used as dual beds.

The audit has resulted in one identified area of improvement relating to ensuring that activities plans are reviewed as part of the residents' care plan reviews.

Consumer rights

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

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

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

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understand and implement related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to formal interpreting services through the district health board and a Maori health advisor is available if required.

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

The clinical manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.

The Napier District Masonic Trust is the governing body and is responsible for the service provided at this facility. Business and quality and risk management plans are documented and include the scope, direction, goals, values and mission statement of the organisation. Systems are in place for monitoring the services provided including regular monthly reporting by the quality and operations manager to the governing body.

Taradale Masonic home and hospital is managed by an experienced and suitably qualified manager. A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection prevention and control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality meetings with discussion of trends and follow up where necessary. Adverse events are documented and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off when completed. Formal and informal feedback from residents and families is sought to improve services. Actual and potential risks are identified and mitigated and the hazard register reviewed is up-to-date.

A suite of policies and procedures are available which are current and have been reviewed regularly to cover the necessary areas.

The human resources management policy is based on current practice and guides the system for recruitment and appointment of staff. A comprehensive orientation and staff education programme ensures staff are competent to undertake their role. A systematic approach to identify, plan and facilitate training supports safe service delivery and includes annual performance review.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster of clinical and non-clinical staff on call after-hours. There is adequate staff to cover the reconfiguration of 12 beds as dual purpose. The staff are trained to manage additional hospital level residents if required.

Resident information is accurately and securely stored. Information is not accessible to unauthorised people. Up to date, legible and relevant residents' records are maintained in using an integrated record.

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 low risk.

The nursing staff is responsible for the development of care plans in consultation with the residents, staff and family/whanau representatives. Care plans and assessments are developed, reviewed and evaluated. The audit has resulted in one identified area of improvement relating to ensuring that activities plans are reviewed as part of the residents' care plan reviews. Short term needs care plans are consistently developed when acute conditions are identified.

Planned activities are appropriate to the residents' assessed needs and abilities. Residents and family/whanau expressed satisfaction with the activities programme in place.

There is a medication management system in place that meets legislative guidelines and policy requirements. Medication is administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) according to policy.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

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 facility has been purpose built. There are single rooms including some with ensuite bathrooms, all of an adequate size to provide personal care.

All building and plant complies with legislation and a current building warrant of fitness was displayed. A preventative and reactive maintenance programme is implemented. There is availability of additional resources and equipment such as hoists and wheelchairs in readiness for the approval of 12 existing beds to be dual purpose.

Communal areas are spacious and maintained at a comfortable temperature. Shaded areas are provided in the summer. Appropriate seating is available in the external areas and gardens.

Implemented policies guide the management of waste and hazardous substances. Personal protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry and cleaning is undertaken onsite with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to an emergency power source is available. Residents report a timely response to call bells. A contracted security company monitors the facility each night.

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.

There are clear and comprehensive documented guidelines on the use of restraints, enablers and challenging behaviours. There were nine residents using restraint and none using enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing restraint education.

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 management systems are in place to minimise the risk of infection to residents, visitors and service providers. The infection control coordinator is responsible for coordinating education and training of staff. Documentation evidenced that relevant infection control education is provided to staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. Surveillance for infection is carried out as specified in the infection control programme.

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	49	0	1	0	0	0
Criteria	0	100	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Staff receive education related to the Health and Disability Commissioner's Code of Health and Disability Services Consumer's Code of Health and Disability Consumer's Rights (the Code) as part of their orientation programme. On-going education on the Code of Resident's Rights has been provided as per the education plan sighted. Staff demonstrated a good understanding of the requirements of the Code and how these are incorporated in practice. Staff were observed knocking before entering resident's rooms and closing the doors when providing personal cares to the residents. Residents were also addressed by their preferred name. New residents and their families are provided with a copy of the Code on admission and copies were displayed throughout the facility. Residents and families reported that staff respect their rights, provide privacy and maintain dignity. The resident and family satisfaction surveys confirmed this.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the	FA	There is an informed consent policy. Residents' records contained completed general consent forms as well as consent forms for specific treatments. Resuscitation and advance directive forms were also sighted in the residents' records sampled. Residents and family members interviewed reported that residents were given the opportunity to make informed choices and that consent was obtained and respected. Interviewed family members also

information they need to make informed choices and give informed consent.		reported that they were kept well informed about what was happening with the resident. Interviewed staff were able to demonstrate a good understanding of the consent process and were able to give examples of how they obtained consent on an on-going basis.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents and families are given a copy of the Code information on advocacy services during admission. Posters on advocacy and pamphlets are displayed in the facility. Interviewed residents and families are aware of the advocacy service and how to access this when needed. The community advocacy service has provided in-service education for staff and an advocate when required. Information on the advocacy service is part of the staff orientation programme.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Interviewed family members stated that they felt welcome when they visit. When residents are able they are encouraged to maintain links with family/whanau and the community including visits to their local church. Regular outings are arranged for the residents as well as attending other community events. Residents are also supported to access health care services eternal to the facility such as their own GP and dental services. Residents and family members confirmed residents are able to continue their links with the community. Van outings are arranged into the community as part of the recreational programme.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints management policy details residents will be informed of the complaints process on entry to this service. The right of the resident or significant others to complain is noted in policy. The complaints reporting, investigation and follow-up process is detailed along with the timeframes. The policy complies with the requirements of Right 10 of the Code. The clinical manager is the complaints manager and works closely with the manager. The clinical manager can seek advice from the clinical nurse specialist for gerontology at the DHB if required. A complaints register is maintained. Complaint management information is included in the resident information packs given on admission and as confirmed by the administrator interviewed. The process is discussed with family/whanau and residents as part of the pre-admission and admission process. Complaints forms are available at reception and in all service areas of the facility. Interviews with staff including registered nurses, healthcare assistants, diversional therapists, domestic staff, the cook and others verified staff are well informed about the rights of residents/family/staff to make a complaint. Interviews with family members confirm their understanding of the complaints process. The complaints register identifies all complaints received and closure dates are recorded when actioned

		appropriately. Complaints information is used to improve services as appropriate. Any improvements are worked through as corrective actions. Any quality improvements or trends identified are reported to the staff. There have been 12 complaints since the previous audit with one presently remaining open. The manager confirms there are no external complaints or issue-based complaints presently inclusive of coroner's inquests or police investigations since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Documented procedures and interviews with residents, families and staff confirmed that resident's rights are understood and are met in everyday provision of care. Information about the Code, advocacy services and the complaints process are provided on admission and are displayed in both Te Reo and English. The Code is also included in the information pack provided to residents and families on admission. Access to interpreters is available. The administrator interviewed reported that on admission the admission agreement is fully discussed with the resident and family. Residents interviewed confirmed this did take place.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service has established systems in place to ensure that residents' privacy is maintained, independence is supported/encouraged and they are treated with respect. All residents' clinical records are securely stored. Residents are being supported and encouraged to personalise their rooms. Staff provide privacy when providing cares to the residents. Interviewed residents and families reported that they are treated with respect and that their individual needs are met. The 2017 resident satisfaction survey confirmed this. The policy on abuse and neglect is well-understood by staff members interviewed. All newly employed staff undergo the police vetting process as part of the employment process and records confirmed that those checks have been completed. Care plans reflect that residents are encouraged to maintain independence and resident's individual cultural, religious and social needs are documented. Residents and their families are involved in the development of the care plans.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori	FA	There are currently no residents who identify as Maori. Cultural beliefs are part of the admission process and this is reflected in the relevant section of the care plan. Documentation is in place to guide staff to ensure residents' needs are met in a manner that respects

have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.		and acknowledges their cultural values and beliefs. The Maori Health Plan is in place and cultural awareness is provided as part of the staff education programme.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Resident's personal preferences and special requirements are included in care plans. Residents and families are involved in the development of the care plans as well as ongoing reviews. Residents and families reported that they have been consulted during admission about the resident's individual cultural and spiritual values and beliefs. They also confirmed that these values and beliefs are respected.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Residents and family members interviewed reported that residents are free from any type of discrimination or exploitation. The staff orientation programme includes professional boundaries and expected behaviours. Ongoing education on discrimination and professional boundaries is provided to staff and this was confirmed during the interviews. Staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect abuse or exploitation of a resident.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Clinical policies and procedures are available to the staff to guide their practice. These reflect good practice and are used in the everyday provision of care to the residents to ensure services are delivered to an appropriate standard. Allied health professionals provide input to the care of the residents as evidenced in resident's records sampled. Regular in-service education/training is provided as well as on-line external education focused on best practice. The general practitioner (GP) confirmed satisfaction with the standard of care provided to residents as well as the clinical competence of enrolled nurses (ENs) and registered nurses (RNs) to perform their roles.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	Resident records contain evidence of effective communication with residents and families. Family members are contacted when acute conditions are identified or after each GP visit. Staff abide by the open disclosure policy reviewed. Resident and families reported that they were kept informed of any changes to the residents' health status and were advised in a timely manner when incidents and/or accidents occurred. There is also evidence of resident and family input in the care plans sampled.

communication.		It is reported that interpreter services can be accessed via the local district health board or alternatively the national interpreter 24 hour service if required. A Maori health advisor is available and accessible if needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The organisation's philosophy, mission statement and values are clearly documented and displayed at the entrance to the facility and discussed at staff meetings. The Napier District Masonic Trust has a strategic business plan in place which has been reviewed by the board. Strategic planning sets goals and objectives for the coming year and they inform the quality plan. Quality data collected throughout the year is used in forward planning where relevant. The quality plan describes how the organisation's goals are monitored and evaluated by the general manager (GM) (who oversees the retirement village) and senior board and staff to ensure residents' needs are being effectively met. There are 11 trust board members including the chairperson. The organisation team interviewed consisted of the GM, finance manager, property and compliance manager (new position), quality and operations manager, administration manager, nurse educator and the clinical manager. Monthly reporting of data is reviewed at board level and discussed at the staff and RN meetings. Outcomes of corrective actions are included in reported data. The GM interviewed explained the process and meets regularly with the quality and operations manager to discuss any issues or concerns. On the day of the audit there were 65 beds occupied. The contracts the service has with the DHB are aged related residential care (ARRC) medical and geriatric continuing care (hospital) with (27) residents receiving this level of care and rest home level care (38). The service provider interviewed reported that the service was able to provide staff both clinical and non-clinical for the 12 bed configuration requested to be dual purpose. Staff manage the hospital and rest home level care residents currently to a high standard. The clinical manager and registered nurses interviewed supported the dual purpose beds and the increased capabilities of staff to manage additional hospital level residents in this care setting. The manager (quality and operations) has been with the organisation for seven years but this particular role for six years at this facility and is responsible for the day to day running of the services, non-clinical, quality management, system changes, projects and reviewing of policies and procedures. The quality and operations manager has a post graduate master degree in quality systems and previously held a role at the DHB as quality coordinator for the laboratory services. The manager attends the annual New Zealand Aged Care Association conference and records were reviewed. The clinical manager and quality and operations manager attend meetings at the DHB in relation to aged care. The manager has completed the management interRAI training. The quality and operations manager is well supported by the clinical manager, clinical coordinator and registered nurses. The quality and operations manager is also responsible for the staff and quality management of another aged care facility. All staff maintain the

		required education for the role they undertake. Interviews with residents and family confirmed that they are happy with the services provided and that they can discuss any issues with the quality and operations manager and/or the clinical manager at any time owing to the open door policy. Positive management interaction with residents, family and staff was observed during the audit.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During the temporary absence of the quality and operations manager the clinical manager is able to ensure the day–to-day operation of the service continues. The clinical manager is an experienced registered nurse. The clinical manager is prepared to manage the reconfiguration of dual purpose beds and ensure the service is managed in an efficient and effective manner to ensure the continuing provision of timely, appropriate and safe services to residents irrespective of whether the residents are requiring hospital or rest home care level. The human resource manager is available for any staffing issues and the GM is available for additional support if required.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The service has a quality and risk management system which was understood and implemented. This includes the development of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection prevention and control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared at staff meetings as confirmed in meeting minutes sighted. Policies and procedures are up to date and reflect current good practice. The next due date for policy review is shown and there is a process in place to manage obsolete documents. Storage is maintained in secure facility sighted. Records can be retrieved as needed. Policies and procedures are available to all staff. Quality data is analysed and evaluated. Trends are identified against previous data. Information is used to inform annual objectives to ensure services meet resident needs. The service has an active fall prevention programme which includes physiotherapy reassessments. This is confirmed in resident records reviewed. Information is also gathered from the annual resident satisfaction survey and any issues that arise are addressed by the management team. The 2017 resident survey was reviewed. No themes of dissatisfaction had been noted. The 2018 survey is taking place and a box is positioned at reception for resident/family to place completed survey when completed. Review processes for corrective actions include internal audit findings, staff meeting discussions and

		monthly sign off by the quality and operations manager. The service has a risk management register which covers all aspects of service delivery. Risks are named and potential consequences, probability and control effectiveness are monitored by the board at the annual planning meeting. Actual and potential risks are identified and documented in the hazard register showing how the risks are managed and the required monitoring frequency is decided according to the risk rating. Hazards are monitored and documented in the hazard register reviewed. This is part of the health and safety programme. Any new hazards are communicated to staff and residents as appropriate. Staff interviewed understood and implemented the hazard identification processes. Actions taken are identified in the health and safety minutes sighted. Staff, resident and family interviews confirmed any concerns they have were addressed by management.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Adverse event reporting is clearly described in policy. The quality and operations manager confirmed awareness of statutory and /or regulatory reporting obligations including adverse events or infection outbreaks. Healthcare assistants interviewed stated that they report any incidents to the registered nurses and then this is recorded into the electronic incident system. The RN puts into place any immediate action and reports the incident to the clinical manager. The falls incidents are categorised using the same system as the DHB and recorded in the data base. Information is shared at all levels of the organisation including any follow-up actions required. Separate rest home and continuing care incidents are tracked and graphs are developed for each service. From a quality perspective this works effectively for frequent fallers. There are seven overarching groups that incidents are placed into such as falls, environment, equipment, personal aids, medication, clinical, action and other. Residents may require input of the physiotherapist or the restorative team (multidisciplinary team) and/or a GP review may be required or appropriate referrals as needed from the outcome of the incident. Interviews and documentation sighted confirmed family are notified of any adverse events or concerns staff have about residents. The quality and operations manager confirmed that information gathered from incident and accidents is used as an opportunity to improve services where indicated.
Standard 1.2.7: Human Resource	FA	Policies and procedures identify human resource management that reflects employment practice that

Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		meets all legislative requirements. The staff records reviewed contained completed orientation records, competencies related to roles performed, staff education, reference checks and police checks. There is a system in place for verifying that staff who require annual practising certificates have them validated upon commencement of employment and annually. Contracted health professionals are reviewed under the same process and records are maintained. Some competencies such as medication competencies and palliative care are performed annually. Position descriptions are available for each individual role. The human resource manager was interviewed. Records reviewed were well maintained and a checklist was sighted in the front of each record sighted. The nurse educator was interviewed and the education plan was discussed. Al mandatory and elective education is provided. There are individual staff education attendance records covering both on-site and off-site training and education attended. The educator also has a spread sheet electronic system for recording all staff education. RNs and ENs are encouraged to maintain a portfolio and three RNs maintain their professional development via the DHB. The education plan sighted identifies that staff undertake training and education related to their roles. Topics covered in annual training and education relates to aged care and health care services. For off-site in-service education the service is linked into the DHB for additional clinical education offered annually. There are currently six registered nurses who have completed the interRAI training. Healthcare assistants have also completed recognised aged care qualifications. Dementia training is encouraged although the service does not have secure dementia service. The registered nurses are well prepared and knowledgeable to manage all current residents. The service is planning a reconfiguration of 12 existing beds to be dual purpose providing rest home and hospital level care to residents. Staff are prepared to meet any additional educational requirements should this be required to meet the needs of residents. Resident and family members interviewed confirmed that services are delivered in a professional manner and that their needs are met by the service.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Policy is implemented to ensure staff experience and skills match the requirements of the services offered. Six weeks of rosters are prepared but are displayed two weeks in advance. The rosters show that the staffing levels meet contractual requirements. Staff stated they can complete all tasks within the allocated work hours and if additional assistance is required the RN or clinical manager is contacted. There is evidence that staff are replaced for sick leave and annual leave. Staff can apply for sick leave and annual leave as needed. The human resource manager interviewed stated that the service rarely uses agency staff. The healthcare assistants interviewed are rostered with consent and planned orientation around the facility and stated they like the variety, flexibility and continuity of care. Staffing levels and skill mix meet contractual requirements and the changing needs of residents. The

		service provider is prepared to provide additional staff as required to cover any increased needs or acuity of residents with the planned configuration of making12 existing beds dual purpose when and if required. Residents interviewed stated all their needs have been met in a timely manner. Family members stated there are always staff available should they have any questions. The clinical coordinator and the clinical manager work every day Monday to Friday. There is an on call system for after-hours providing support from a registered nurse. All shifts are covered by a registered nurse.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and to track records. This includes information gathered at the time of admission to the service with the involvement of family. There is sufficient detail in the residents' records to identify residents' ongoing care history and activities. The individual national health index number is documented for each individual resident. There are policies and procedures in place to ensure privacy and confidentiality is maintained. Staff interviewed understood the reasons for maintaining confidentiality. Residents' records are protected from unauthorised access by being in the nurses' stations in each service delivery area. The door to the nurses' station is also locked. Entries in the sampled residents' records are legible, dated and signed off by the relevant staff member or allied health professional making the entry. The individual resident's records demonstrated service integration with labelled divisions inclusive of medical interventions, allied health input and other correspondence. Allergies and sensitivities if known are documented on the clinical records in each record sighted. Medication records are maintained electronically as part of the medication system utilised.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Taradale Masonic Home and Hospital's welcome pack contains information about entry to service. A request for bed initial enquiry form is completed. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Records sampled confirmed that admission requirements are conducted within the required time frames and are signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services provided.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management system is implemented to ensure that residents receive medicines in a secure and timely manner. Medication entries sampled on the electronic system complied with current legislation, protocols and guidelines. Medications are stored in a safe and secure way in the locked drug trolley and cupboards. Medication reconciliation is conducted by the RNs when the residents are transferred back to service. The service uses the electronic system for e-prescribing, ordering, dispensing and administration. The system is accessed by use of individual passwords. All medications are reviewed every three months and as required by the GP. Allergies are clearly indicated, and photos uploaded for easy identification. The controlled drug register is current and weekly and six-monthly stock takes are completed and all medications are stored appropriately. There were no expired medications that needed to be returned to the pharmacy. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The RN was observed administering medication correctly. The registered nurses are prepared to manage the medication management for the hospital or rest home level residents with the planned configuration of changing 12 existing beds into dual purpose beds. The one resident self-administering medication at the time of the audit was assessed as competent. Records were being maintained and medication stored in a locked container. There is a policy and procedure for self-administration of medication.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The meals are prepared on site and served in the respective dining areas. The menu has been reviewed by a dietitian. The kitchen has been registered and audited by the local council under the food control plan. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The nutritional needs are provided in line with recognised nutritional guidelines appropriate to the residents at the service. The kitchen staff ensured there will be no required changes to the food service to accommodate the planned configuration to change 12 existing resident beds into dual purpose beds. A client food preference sheet is developed on admission which identifies dietary requirements, likes and dislikes. Supplements are

		provided to residents with identified weight loss issues. Fluids are provided to residents as required and fluid intake monitoring is completed as indicated. The kitchen and pantry were observed to be clean, tidy and stocked. Labels and dates are on all containers and records of temperature monitoring food, fridges, freezers and chiller are maintained. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. All decanted food had records of use by dates recorded on the containers and no expired items were sighted. In interviews, residents and family/whanau expressed satisfaction with the food service.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	The clinical manager reported that whenever a consumer is declined entry, family/whanau are informed of the reason for this and other options or alternative services available and this is indicated on the request for bed initial enquiry form. The consumer is referred to the referral agency to ensure that the consumer will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The initial assessments are completed within the required time frame on admission, while care plans and interRAI assessments are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. The nursing staff utilise standardised risk assessment tools on admission. In interviews conducted family/whanau expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	The assessed information is used to initiate care plans and short- term needs care plans for acute needs. Goals are relevant, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. The residents and family/whanau interviewed confirmed care delivery and support is consistent with their expectations and plan of care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate	FA	The documented interventions in short term needs care plans and long term care plans are adequate to address the assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview

and appropriate services in order to meet their assessed needs and desired outcomes.		conducted. Daily flow charts are completed on every shift. Monthly observations are completed and are up to date. Adequate clinical supplies were observed, and the staff confirmed they have access to the supplies and products they needed.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is a full range of social activities that are available on the weekly programme for all residents to participate in. The activities are used to facilitate emotional and physical wellbeing. The activities can either be individual or group activities conducted under the guidance of the diversional therapists and rehabilitation/activities coordinator. All the activities evidenced documented evaluations on the residents' participation. Residents' files have a documented activity plan that reflects their preferred activities of choice. A quality improvement project to improve communication methods relating to activities within the service was completed. Effective strategies of communication were identified and implemented in consultation with staff, residents and their families. This resulted in the significant increase in attendance to the daily programmes. The residents were observed participating in a variety of activities on the audit days. Residents were observed going offsite with family/friends and with several community organisations providing activities at the service. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. The audit has resulted in one identified area of improvement relating to ensuring that activities plans are reviewed as part of the residents' care plan reviews Refer to 1.3.5.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	InterRai assessments and long term care plans are evaluated/reviewed in a comprehensive and timely manner. Reviews are fully documented and include current resident's status, any changes and achievements towards goals. Family/whanau, residents and staff input is obtained in all aspects of care and care plans are reviewed/evaluated accordingly. Short term needs care plans are developed for acute needs. The audit has resulted in one identified area of improvement relating to ensuring that activities plans are reviewed as part of the residents' care plan reviews. Refer 1.3.5.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is	FA	There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers and internal transfer forms for internal transfers. GP confirmed that processes are in place to ensure that all referrals are followed up accordingly. Resident and family are kept informed of the referrals made by the service. All referrals are facilitated by the RNs or the GP.

appropriately facilitated, or provided to meet consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances were in place. Infection prevention and control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal. The doors to the areas storing chemicals were secured and containers are labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. The material data sheets were on the wall in the laundry and in the cleaner's cupboard. Any related incidents are reported by staff in a timely manner. There is provision and availability of personal protective clothing and equipment and staff were observed using this including aprons, gloves, masks and hats. There were adequate stores sighted in the cleaner's cupboard and throughout the facility to ensure the service providers are able to support the proposed 12 existing resident beds being changed to dual purpose beds. The maintenance staff had access to overalls, ear plugs and hearing protectors as needed.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The current building warrant of fitness expires 01 November 2018 and is publicly displayed at the entrance to the facility. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. The individual resident rooms sighted are large enough to accommodate transfer hoists and wheelchairs to meet the needs of hospital level residents. Additional equipment is available if required to meet the requirements of 12 existing beds being utilised as dual purpose beds. There is a proactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of biomedical equipment is current as confirmed in documentation reviewed. The newly employed property manager was interviewed as part of the management interviews and was able to explain the role. The maintenance person was not interviewed but all records were made available during the audit. External areas are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environment is hazard free and that residents are safe. There is a health and safety committee who meet regularly and report back at the quality meeting. A hazard register is maintained and is up-to-date. Residents interviewed confirmed they know the processes they should follow if any repairs or maintenance are required. All requests are actioned and they are pleased with the environment.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There is a mix of toilets and showering facilities throughout the services. This includes rooms with ensuite bathrooms, shared bathrooms between two rooms, stand-alone shower rooms with external door into the hallway and four studio rooms with ensuite bathrooms. All rooms in the rest home wing have a separate toilet and a hand basin in all rooms. There is a wing of six rooms with their own ensuite. There are appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote resident independence and safety. A variety of hoists are available to assist staff when attending to the hygiene needs of hospital and rest home level residents. Staff are prepared to meet the needs of either additional rest home or hospital level residents with the planned refigured service of 12 dual purpose beds if and when approved.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provided single accommodation. There is one married couple who share two rooms, one is currently made into the lounge and the other room is the bedroom with two beds. The bathroom and toilet is between the two rooms. Rooms are personalised with furnishings, photographs and other personal items displayed. A separate storage area is provided for mobility aid scooters with recharging facilities as needed. There is room for a variety of hoists to be stored as well. No additional storage or personal space would be required if 12 existing beds are changed to be used as dual purpose beds.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy if required. Furniture is appropriate to the setting and resident needs. The furniture is arranged in a manner which enables residents to mobilise freely. There is one small lounge near the continuing care rooms especially designated for family members if a resident is receiving palliative care. It is self-contained with a kitchenette and a lounge area. The call system is evident in this room and a telephone is set up and is accessible. Privacy can be maintained.
Standard 1.4.6: Cleaning And Laundry Services	FA	There are documented procedures in place for cleaning and laundry services to guide staff. All laundry is undertaken onsite in a dedicated laundry. The laundry sighted is staffed seven days a week. The laundry is purpose built and spacious and has all new commercial appliances that are monitored by the

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		contracted provider. All temperatures are monitored regularly and adjusted by the contracted provider if necessary. The laundry assistant interviewed works five days a week Sunday to Thursday with another assistant working Friday and Saturday. Another assistant a few hours two days per week. An additional laundry assistant works afternoon on the busy linen change days to help with folding and deliveries to residents' rooms. Resident's personal items are laundered on site or by family if requested. Residents/family interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by laundry staff who demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Staff receive training and chemicals are stored in a lockable cupboard in appropriately labelled containers. Material data safety sheets are readily available. The laundry, sluice rooms and the cleaner's cupboards have swipe card access only. Both cleaning and laundry processes are monitored through the internal audit programme reviewed. Cleaning equipment is securely stored including the cleaning trolley when not in use.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The emergency response plans were reviewed 18 June 2018 by the organisation. The current fire evacuation plan was approved by the New Zealand Fire Service on the 2 October 2013. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service. The most recent fire drills were held on the 14 June 2018 and the 27 June 2018 with a good attendance of staff at each trial evacuation. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. The organisation's robust emergency and business continuity plan was reviewed May 2018. Staff reported that no additional changes would be required for the planned reconfiguration of changing12 existing beds to dual purpose beds. Adequate supplies for use in the event of a civil defence emergency, including food and portable (i.e drinking) water, first aid equipment, blankets, mobile phones, emergency keys, torches and a gas barbecue are available and meet the requirements for the number of residents. Water storage tanks are located in the complex and there is a diesel generator on site. Emergency lighting is regularly tested. Gas mains provide the main source of heating with a supply of electric column heaters available as an alternative heating. Nurse call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells. Adequate security arrangements are in place. Doors are alarmed with summer and winter times and

		after hours entry is by swipe card access only. Staff ensure doors and windows are closed and locked in the evening and night shifts. A security company is contracted to monitor the village security after-hours.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas have opening external windows. Most have doors that open onto outside garden areas. The facility is all on ground level. Heating is provided either by underfloor or by radiators in each room and bathroom and throughout the communal areas (the heating is supplied by gas boilers heating water which then ends up in the facility either in the radiators or underfloor heating pipes in the newer areas). Some communal areas have additional heat pumps. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature. No changes would be required in respect of the planned reconfiguration of 12 existing beds changing to dual purpose beds.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	Taradale Masonic Home and Hospital provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The RN is the infection control coordinator (ICC) and has access to external specialist advice from a GP, external consultant and DHB infection control specialists when required. A documented job description for the ICC including role and responsibilities is in place. The infection control programme is reviewed annually and is incorporated in the monthly meetings and a review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and electronic progress notes. The infection control programme is appropriate for the size and complexity of the service. There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks reported since the last audit and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme.
Standard 3.2: Implementing the infection control programme There are adequate human,	FA	The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICC has

physical, and information resources to implement the infection control programme and meet the needs of the organisation.		access to all relevant resident data to undertake surveillance.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The organisation has documented policies and procedures in place that reflect current best practice. Staff were observed to comply with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is conducted by the ICC. A record of attendance is maintained and was sighted. The training education information pack is detailed and meets best practice and guidelines. External contact resources included: GP; laboratories; external consultant and local district health boards. Staff interviewed confirmed an understanding on 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 infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.
Standard 2.1.1: Restraint	FA	The assessment, approval, monitoring and review process is the same for both restraints and enablers. An updated restraint register was sighted, and staff interviewed understand the difference between

minimisation Services demonstrate that the use of restraint is actively minimised.		restraint and enablers. Risk minimisation is documented in the care plans of the residents and restraint is evaluated regularly. Approved equipment which can be used as restraint includes, bedrails, chair support briefs, bars on toilet or shower chairs and fixed furniture/tables. There are currently nine residents on restraint and none using enablers for safety and comfort. The family and residents are fully informed about the restraint process and risks involved. All staff complete a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.	FA	The clinical coordinator is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed according to restraint minimisation and safe practice standards. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability for restraint use. The approval process is in place and includes: the clinical nurse coordinator, GP and a family representative. Restraint use is discussed in management and staff meetings.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	The restraint assessment process is fully documented and includes the requirements of this standard. Residents' records sampled confirmed completed assessments and approvals. Assessments and approvals were signed by the resident or family, the GP and the restraint coordinator. The assessment identified the cause, alternatives, risk, cultural considerations and outcomes. The most common reason for implementing a restraint in the records sampled is for safety reasons.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	All restraints are used as a last resort. Discussions regarding trialled alternatives were sighted in records sampled. Once in place, restraints are monitored for safety. Bed rails have protective covers. All residents on a restraint are monitored every hour. There have been no reported incidents related to unsafe restraint use.

Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Regular reviews are conducted on residents with restraints and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included discussions on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Interviewed staff and family/whanau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint in use and the risk management plans documentation in the long term care plans. Evaluations time frames are determined by the risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service has demonstrated monitoring and quality review on the use of restraints. Restraint updates are included in the monthly staff meetings and continuous quality improvement summary reports. Individual approved restraints are evaluated three monthly through a restraint meeting and as part of the facility approval team review with family/whanau involvement. The clinical coordinator reported that assessments and monitoring are appropriate. Policies and procedures are up to date and a training record was sighted and annual reviews are done.

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 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	PA Low	Not all activity plans sampled have been reviewed and linked to the ongoing assessment process. Care plans are resident focussed, integrated and provide continuity of service delivery.	Activity plans are not being reviewed in conjunction with InterRAI assessments to achieve the desired outcomes.	Provide evidence that activity plans are being reviewed along with InterRAI assessments. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.