

# Discover Oasis Limited - Concord House Rest Home

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Discover Oasis Limited
<b>Premises audited:</b>	Concord House Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 November 2018      End date: 13 November 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	11

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	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

Concord House provides rest home level care for up to 15 residents. On the day of the audit there were 11 residents living at the facility.

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

The facility manager is supported by a registered nurse. Residents interviewed were complimentary of the service they receive.

The service has addressed five of the nine previous audit shortfalls around; signed admission agreements, essential notification, self-medication documentation, material safety datasheets, and environmental restraint. Further improvements continue to be required around the employment process, orientation, care plan timeframes and care interventions.

This audit identified six further areas for improvement around; family communication, kitchen management, implementation of the quality programme, staff training, activities for residents, evaluation of care plans and the environment.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Information about the services provided is readily available to residents and families/whānau. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is available in the information presented to residents and their families during entry to the service. The process around managing complaints meets HDC requirements.

## 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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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management programme is documented. A risk management programme includes incident and accident reporting. Adverse, unplanned and untoward events are documented by staff. Registered nursing cover is available on site or on call twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

## 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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Assessments, care plans are completed by the registered nurse. The interRAI assessment informs the care plan. Short-term care plans are in use for health changes.

Activities for residents are provided by caregivers.

There is an established system of medicines management in place. The caregivers and the registered nurse have completed medication competencies.

Food services policies are appropriate to the service setting. Resident's individual dietary needs are identified, documented and reviewed on a regular basis.

Residents interviewed were complimentary about service delivery.

## 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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The service displays a current building warrant of fitness. The building is a two-storey building consisting of a ground floor and a basement area. All resident areas are located on the ground (i.e. upper) floor. All resident rooms are single occupancy except for one room. Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access to outdoor areas and decks. The external area provides seating and shade.

## 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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. There are no residents with restraint or enablers.

## 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 prevention and control programme is suitable for the facility. The programme is led by the registered nurse with support from the facility manager. The programme is based on defined policies and procedures. General practitioners are actively involved in the management of residents with suspected infections. Trends are able to be identified. There have been no outbreaks of infection in the rest home in the period since the previous audit.

## 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	10	0	5	4	0	0
Criteria	0	34	0	6	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 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	<p>The service has policies and procedures relating to informed consent, resuscitation and advanced directives. Residents are required to sign an admission agreement on entry to the service. The service uses an industry template, which includes the requirements of the aged residential care agreement.</p> <p>All five files reviewed included signed agreements. This is an improvement from the previous audit. Each file included signed consents and resuscitation instructions. Staff were aware of advanced directives.</p> <p>Discussions with residents identified that the service actively involves them in decision making.</p>
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The complaints procedure is provided to residents and families during the resident's entry to the service. Access to complaints forms are available. No complaints have been received since the new owners purchased the facility in March 2016. Discussions with residents (two through an interpreter and two spoke English) confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p> <p>As well as resident meetings the service has implemented resident welfare checks</p>

		each week, where a selection of residents are interviewed, and outcomes are documented and acted upon. This process has enabled residents to provide input to services and any issues raised are acted upon very quickly.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>There is a policy to guide staff on the process around open disclosure. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms and care plans reviewed did not evidence relatives are informed of any incidents/accidents. There were no visitors/relatives on the days of audit.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Most residents at the service were mandarin speaking, and staff provide interpreter services as needed. Signage is posted in visible locations in English and Mandarin. Two Chinese residents were interviewed with the assistance of an interpreter. They reported that communication is good.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Concord House provides rest home level of care for up to 15 residents. On the day of audit there were eleven residents including one younger person disabled funding (YPD) and one resident under ACC funding. The YPD resident was over 65 years of age.</p> <p>There is a documented business plan in place dated '2016 - 2017 onwards'. Goals are documented around occupancy, staff turnover and the facility's reputation with the community. The service is currently in the process of reviewing business and quality processes.</p> <p>The facility manager holds a degree in architecture. This is her first role in aged care. She attends DHB age-related cluster meetings every two months. She is assisted by an RN on a short-term contract who is employed to work 10 – 20 hours per week and is on call when not available on site. The RN is completing a master's degree in nursing, including subjects such as gerontology, nursing leadership and assessment skills. The manager advised that a new graduate Chinese speaking RN who has previously worked at the service as a caregiver may take on the permanent role after Christmas. She also advised that consideration is being given to supporting the new RN with the experienced RN currently in the short-term role.</p>
Standard 1.2.3: Quality And Risk Management Systems	PA Moderate	Policies and procedures align with current good practice and meet legislative requirements. Policies have been updated to reflect processes around interRAI and

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>pressure injuries. They are regularly reviewed as per the document review schedule. A system for document control is in place. New policies and updates to existing policies are discussed in staff meetings.</p> <p>There is a documented quality programme in place, however this has not always been followed. Meetings and internal audits have not always been undertaken as scheduled.</p> <p>Adverse event data is entered on-line and collated and compared month by month. The service has updated the computerised incident collation process with a new system commencing the week prior to audit.</p> <p>Quality data and results, including any resident feedback, is reported in the staff meetings, evidenced in the meeting minutes and in interviews with four staff (two care staff, one cook, one registered nurse).</p> <p>A risk management plan is documented as part of policies and procedures. Health and safety is an agenda item at all staff meetings. The manager is the health and safety officer along with the RN. The service was able to demonstrate that hazard forms are generated as a result of incidents, however there was no hazard register on the day of audit. The meeting minutes include an agenda item for health and safety, however hazards were not documented as discussed.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. Residents at risk of falling are discussed in the monthly staff meetings.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed on the computer system for each incident/accident with immediate action noted. Observations are recorded for suspected injuries to the head. Incident/accident data is linked to the quality and risk management programme. Five accident/incident forms were reviewed. Each event involving a resident, reflected follow-up by the registered nurse.</p> <p>Statutory responsibilities are documented in policy and the facility manager was able to explain her responsibilities. No section 31 notification has been required since the previous audit. However, the manager could describe reporting processes. This is an improvement on previous audit.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are</p>	<p>PA Low</p>	<p>Human resources policies and procedures are documented. All five staff files reviewed (one RN, one cook and three caregivers) included evidence of signed</p>

conducted in accordance with good employment practice and meet the requirements of legislation.		<p>employment contracts. Missing was documented reference checking for the new RN who has been employed since the previous audit. This is a continued shortfall from the previous audit. Job descriptions were in place for all five staff files and had been signed by staff; this is an improvement from the previous audit.</p> <p>A general orientation programme that includes health and safety is documented that provides new staff with relevant information for safe work practice. This was not evidenced in the two new staff files reviewed and this is a continued shortfall from the previous audit.</p> <p>Annual appraisals were not documented in any of the three staff files reviewed who had been at the service for over a year.</p> <p>Current practising certificates were sighted for the RN, GP, physiotherapist and pharmacy. There is an annual education schedule documented. A review of staff files and the training files evidenced that no training had been documented since 2016. The service contracts with an on-line training service and staff are advised what training is due at staff meetings. However, the service does not follow up with staff to check if training has taken place and no records are maintained of attendance.</p> <p>The RN has completed her interRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy aligns with contractual requirements. A RN is contracted to work at the facility 10 – 20 hours per week depending on need. The RN is on site two – three days per week. When not available on site, she is available on-call and was interviewed during the audit.</p> <p>One caregiver is rostered for each shift. Staffing is flexible to meet the acuity and needs of the residents. Separate staff are responsible for cleaning/laundry (Monday – Friday). Interviews with residents, the GP and staff confirmed staffing overall was satisfactory.</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>	FA	<p>All medicines are prescribed by the residents' GPs (confirmed in review of all eight residents' medicine charts). All medication charts are documented on a computerised medication system. All were recorded correctly and signed correctly by the resident's general practitioner. Allergy status is recorded. Medicines are administered as prescribed by caregivers and signed for correctly. A medicine round was not witnessed, as no residents required medicine administration at lunchtime. All medicines were stored securely when not in use. The facility uses the blister pack medication management system. Medicines are typically delivered every four weeks, unless additional medicines are needed. Medicines are reconciled on delivery by the</p>

		<p>RN prior to use. All medication charts are legible and reviewed three monthly. There are appropriate medication policies and procedures in place including policy for residents who self-administer their medicines. Two subsidised residents were self-administering medicines. Both have lockable drawers in their room and up-to-date assessments signed by the GP. The staff confirmed that the residents have taken their medication each shift. This is an improvement from the previous audit. Standing orders were not in use.</p> <p>Competency for caregivers who administer medicines is assessed annually when due by the RN.</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>	PA Moderate	<p>The service kitchen is off the main dining area. An inspection of the kitchen evidenced that; not all food was covered, labelled and dated, the kitchen cleanliness was not up to date and where food is labelled it is not always in English. There is a food plan in place and is in the process of verification. Cooks are employed to cover seven days. The cooks work from 9.00 am to 1.00 pm and 3.00 pm to 6.00 pm. The majority of food is prepared and cooked on site. The cooks prepare meals to meet both European and Asian preferences reflecting the resident cultural mix. Daily monitoring records are maintained of refrigeration and freezer temperatures, but not food temperatures. Food is served directly to residents in the adjoining dining room. Food services policies and procedures are appropriate to the service setting. There are four weekly menus in place that have been approved by a dietitian. Residents' dietary profiles are kept in the kitchen. Resident preferences are accommodated, and dislikes accommodated. Special equipment is available as needed. Additional fluids and food are available for residents when the kitchen is closed. There are no residents requiring special diets at present. Residents interviewed were complimentary of the food service provided.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>All five resident files reviewed included a long-term care plan. The service is in the process of moving from paper-based care plans to a computer-based plan. All five residents had a combination of paper-based and computer-based plans in place. The computer also includes documented handover information. The service has introduced this measure to ensure that care staff are easily able to access up-to-date information regarding each resident 'at a glance'.</p> <p>Long-term care plans are individually developed with the resident and/or family/whānau, however resident needs were not always documented in the care plans (paper-based, computer-based or handover notes). This is a continued shortfall from the previous audit.</p>

		Residents and family members interviewed stated they are involved in the care planning process.
<p><b>Standard 1.3.6: Service Delivery/Interventions</b></p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's health status changes the RN or facility manager initiates a GP consultation. Clinical specialists from the DHB are available to provide clinical advice and support. Other specialist involvement, including the mental health service is available.</p> <p>The GP interviewed, stated the services provided met expectations and the needs of residents. The GP also confirmed prompt notification of any health changes. No relatives were available at the time of audit. Caregivers interviewed, stated that they have sufficient equipment to provide care as instructed in the care plans. Clinical supplies are available, including adequate wound care and continence products. There were no wounds or pressure injuries on the day of audit.</p> <p>Chair scales are used to weigh residents monthly or more frequently if necessary. Weights are recorded in the electronic patient management system.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>	PA Low	<p>The service employs a diversional therapist (DT) who attends the service every two weeks. Staff described how the DT spends time with residents when he visits. Caregivers were observed interacting with residents, singing and dancing on the days of audit.</p> <p>The registered nurse conducts the social assessment as part of the interRAI evaluation/reassessment process. One resident had an up-to-date individual activity plan, two residents did not have an individual activity plan and two had an activity plan dated 2016 (link to 1.3.8.2). The group activity programme published on the whiteboard was dated April.</p> <p>Caregivers supervise and escort residents who wish to go for daily walks or van rides. The business owns a seven-seater van, which can accommodate five residents, a driver and a staff member. Group activities are held in the lounge. Residents were observed participating in activities with caregivers.</p> <p>Residents interviewed, reported satisfaction with the activities programme. The service receives feedback regarding activities and other aspects of care through resident welfare checks.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a</p>	PA Low	<p>Residents are reassessed using the interRAI process at least six monthly. The RN reassesses residents if there has been a significant change in their health status. The GPs review residents three monthly or when requested. Short-term care plans</p>

comprehensive and timely manner.		are in use and evaluated regularly. Care plans have not all been evaluated at six monthly intervals.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies in place for waste management, waste disposal for general waste and medical waste management. All chemicals are labelled with manufacturer labels. Chemicals are stored safely. Material safety datasheets were posted up in the wall in the sluice room, The manager and housekeeping staff were aware of the sheets and their location. 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>	PA Moderate	<p>The service displays a current building warrant of fitness.</p> <p>The building is a two-storey building consisting of a ground (i.e., upper) floor and a basement area. All resident areas are located on the ground floor. All resident rooms are single occupancy except for one room. There are six bedrooms downstairs that are used by boarders and the facility manager who lives on site. The basement/downstairs area contains the facility manager's office, the laundry and storage areas.</p> <p>There is a reactive and a planned maintenance system in place. The maintenance is completed by contractors and coordinated by the manager. However, the environment has areas of improvement required.</p> <p>Hot water temperature checks are monitored in resident bathroom/shower areas monthly. Records of temperatures sighted were not always 45 degrees Celsius or below.</p> <p>Residents were observed to safely mobilise throughout the facility with easy access to communal areas. There is safe access to outdoor areas and decks. The external area provides seating and shade.</p> <p>Interviews with staff confirmed there was adequate equipment and supplies to provide safe and timely care.</p>
<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	<p>There is a policy describing surveillance methodology for monitoring of infections. Infections are managed in consultation with the resident's GP. They are recorded on a monthly register. The infection control coordinator and facility manager collate information obtained through surveillance. The infection rate is low, with urinary tract infections being the most common type of infection. Infection control data are discussed at both the management and staff meetings. Systems in place are</p>

		appropriate to the size and complexity of the facility. There have been no outbreaks of infection since the previous audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint minimisation and environmental restraint. The facility manager is the designated restraint coordinator. All exit points are freely available to all residents and environmental restraint is not practiced. This is an improvement from the previous audit. There were no other restraints or enablers in use. The caregivers interviewed understand the difference between restraints and enablers.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	The service conducts resident meetings where residents are encouraged feedback regarding services. Incident forms reviewed did not document if family had been informed.	Five incident forms reviewed for October and November did not document if family had been informed following an incident.	<p>Ensure that family are documented as informed following an incident and are part of the care planning process.</p> <p>90 days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and implemented by service providers.</p>	PA Moderate	The service has quality processes and procedures documented that have been developed by an external contractor. However, these processes have not been documented as followed and the service was not able to locate all aspects of the quality process.	The service was unable to locate an internal audit schedule, and no internal audits have been documented except a 'pre-audit check' (which achieved 100% compliance).	<p>Ensure that an internal audit schedule is documented and implemented.</p> <p>60 days</p>

<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	PA Low	<p>There is a documented quality programme in place, however this has not always been followed. Meetings and internal audits have not always been undertaken as scheduled. Quality data and results, including any resident feedback, is reported in the staff meetings, evidenced in the meeting minutes reviewed and in interviews with four staff (two care staff, one cook, one registered nurse).</p>	<p>Staff meetings are scheduled monthly, but these have not always been held monthly. There were no meetings for January, March, May, August, and October 2018.</p>	<p>Ensure that monthly staff meetings are documented as scheduled</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Moderate	<p>The manager is the nominated health and safety representative. Staff interviewed were able to describe who the health and safety representative was and the process for identifying hazards in the work place. The service has hazard identification forms that are entered into the service electronic system. Hazard forms seen were in the process of follow-up or had been followed up and closed off. This process was implemented very recently with hazard identification forms seen from September, October and November. The staff meetings have an agenda item for health and safety, however meeting minutes did not document any discussion under these sections and there was no hazard/risk register available at the time of audit.</p>	<p>(i) There is no documented hazard register for the service.</p> <p>(ii) Identified hazards are not discussed at staff meetings</p>	<p>(i) and (ii) Identify and assess all service risks and ensure a hazard register with mitigating strategies is documented and communicated to staff.</p> <p>60 days</p>

Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The facility manager reported that the appointment of appropriate staff includes an interview, police vetting, and reference checking but reference checking was not documented for the new RN.	The policy requires staff to undergo a formal interview, police vetting and reference checking. The reference checking was not documented for the new RN.	Ensure each staff file includes evidence of reference checking.  90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	An orientation programme is in place that includes orientation to health and safety and being buddied with more experienced staff for job specific duties.	Two new staff files were missing evidence to indicate that they had completed an orientation programme.	Ensure that the content of the orientation programme is documented and signed by both parties when completed.  90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The service has a documented training schedule and contracts with an on-line training service to provide the training. Staff have access to a computer whilst at work and can access the programme from home. The staff meetings document the staff are advised what training is due each month (link to 1.2.3.5). There are no records to evidence if staff have accessed the training. Staff interviewed were not clear about training and did not reference the on-line training.	The service has not documented training for staff since 2016. The requirement for staff to have eight hours of training annually could not be evidenced.	Ensure that staff training is documented to ensure that staff receive at least eight hours of training related to policies and procedures that comply with the ARRC agreement.  30 days
Criterion 1.3.13.5 All aspects of food	PA Moderate	The residents all complimented the meals provided and the service	i) Not all food is labelled, dated and covered. (ii) Not all food	(i) Ensure that all food is labelled covered and dated. (ii)

procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		provides culturally appropriate food for the residents. Not all aspects of kitchen hygiene, food temperatures and food storage management were of a reasonable standard.	labels are in English. (iii) Food temperatures are not documented; (iv) The Kitchen was not clean enough including drawers, kitchen surfaces, doors and cupboards.	Ensure that all food labels are in English (as well as Mandarin if needed). (iii) Ensure that food temperatures are recorded in accordance with the food control plan. (iv) Ensure that all aspects of the kitchen are clean.  30 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>The policy is that residents are assessed by the registered nurse on admission and an initial plan of care is developed to guide staff. A range of assessments are conducted on admission by the RN and shortly thereafter to inform the interRAI assessment process.</p> <p>Residents are assessed by a medical practitioner within two working days of admission. The RN is required to complete the interRAI assessment process within 21 days of admission. Resident files reviewed did not reflect that all documentation was completed within required timeframes. Advised that staff changes resulted in one resident having their interRaAI delayed due to permissions that needed to be updated with interRAI at the time.</p>	Two of three residents who were admitted since the previous audit did not have an interRAI and long-term care plan completed within 21 days. However, all three did have a current interRAI assessment and long-term care plan in place.	<p>Ensure all newly admitted residents have an interRAI and long-term care plan completed within 21 days of admission.</p> <p>90 days</p>
Criterion 1.3.5.2	PA	Each resident has a combination of	(i)One resident's initial assessment	Ensure all plans describe the

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	Moderate	paper-based and an electronic care plan, which is developed by the RN following the resident's interRAI assessment. The electronic plan of care is accessible to caregivers, but not all care interventions were documented in the care plan(s). Caregivers record progress notes electronically at the end of each shift.	and care plan was not fully completed. (ii) Two residents did not have all interventions documented to support assessed needs in their care plan; (a) for one resident 'undernutrition' identified as an interRAI CAP did not have interventions to support the risk in the care plan, and (b) one resident with documented uncooperative behaviour did not have this documented in the care plan.	required support and interventions that staff need to follow when providing care.  90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	The service employs a DT every two weeks and caregivers provided day-to-day activities such as the television, singing and some dancing. There is no documented activity plan and not all residents had a documented individual activity plan.	(i) There has been no group activity plan documented since April. (ii) Two residents had no documented individual activity plan. (iii) Two residents have a documented individual activity plan dated 2016.	Ensure that each resident has planned activities provided and documented that are meaningful and appropriate to resident needs.  60 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	The service reviews the interRAI assessment six monthly. The service, as part of its process to change the care planning documentation, is updating care plans.	(i) Two residents had an individual activity plan that had not been evaluated since 2016. (ii) Four of five resident files did not document an evaluation of care against stated goals.	Ensure that evaluations of care document progress towards stated goals at least six monthly.  90 days
Criterion 1.4.2.4 The physical environment minimises risk of harm,	PA Moderate	Residents interviewed were very happy with the environment and their rooms, with many taking evident pride with their room. The	(i) Bedrooms had chipped and peeling paintwork. (ii) Bedrooms had curtains that did not fit, did not match and were hanging down in	(i) Ensure that the paintwork is repaired. (ii) Ensure that curtains fit the windows and hang from the curtain rails as

promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.		service is spacious and includes enough room for residents to mobilise with their mobility aids as needed. Not all aspects of the environment were of an expected standard.	places. (iii) The disability handle round one toilet had all the padding missing exposing the wood of the arm rest. (iv) Communal toilets had no privacy signs. (v) Water temperatures over 45 degrees were recorded in resident areas with no remedial actions documented.	designed. (iii) Ensure that the disability handles are repaired. (iv) Ensure all bathrooms can ensure privacy. (v) Ensure water temperatures are below 45 degrees in the resident areas.  60 days
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# Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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
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End of the report.