Many Hands Limited - Cornwall Rest Home

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Many Hands Limited
Premises audited:	Cornwall Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 5 June 2019 End date: 6 June 2019

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 27

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 facility is owned and operated by a sole managing director. This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards. The facility can provide care for 27 residents. Occupancy was 27 on the first day of the audit.

The audit process included review of policies and procedures; review of resident and staff files; observations and interviews with residents, family, an advocate, the manager, staff and a nurse practitioner.

There are areas identified as requiring improvement relating to: adverse events; activities; resident evaluations; medicine management; chemical safety and emergency supplies.

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.

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights; complaints process and Nationwide Health and Disability Advocacy Service, is provided to residents and their families on admission to the facility. Residents' cultural and spiritual beliefs are identified on admission and there is access to cultural and spiritual support if required.

Residents and family confirmed that their rights are being met, staff are respectful of their needs and communication is appropriate.

There is a documented complaints management system and a register of complaints is maintained. The complaints reviewed were investigated and managed within the required timeframes.

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.

The facility is owned and managed by a managing director, also known as the manager. The manager is suitably qualified and experienced and has been in the role for nine months. The manager is supported by a registered nurse. A registered nurse with a current practicing certificate works four days per week and is responsible for clinical management and oversight of services. This registered nurse is supported by another part-time registered nurse who works one day per week.

The facility has a strategic plan that documents the mission, values, and scope of the facility. The plan defines the required behaviours, expected outputs and critical success factors for the organisation.

There is a quality and risk management system that supports the provision of clinical care and quality improvement. Policies are reviewed and current. Quality and risk performance is reported through staff and quality improvement meetings at the facility. Reports include clinical indicators, incidents/accidents, infections and complaints management. An internal audit programme is implemented. Corrective action plans are documented and there is evidence of the resolution of issues when these are identified. There is an electronic database in which risks and controls are clearly documented.

A review of staff files and training records confirmed that policies and procedures to guide human resource management are implemented. Recruitment and employment practices are in line with legislative requirements. Registrations with professional bodies are verified annually for all who require these. A training plan is implemented, and in-service education is available for all staff, including mandatory training around clinical service delivery. Staff competency is routinely assessed.

Staffing levels are sufficient across the facility. A registered nurse is on duty eight hours a day Monday to Friday and on-call after hours, seven days a week. The registered nurse is supported by adequate levels of care staff. There is always at least one staff member on duty with a current first aid certificate.

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 residents' records reviewed provided evidence that all residents have been assessed appropriately prior to admission to this facility by the need's assessment service coordinators. The residents' needs, outcomes and/or goals have been identified in the assessments, and long-term care plans are reviewed six-monthly or more often as required.

An activities programme is provided for residents. Participation is encouraged but is voluntary. Interviews with residents confirmed activities are planned that are meaningful to them. Community outings are arranged, and entertainers are invited to participate in the programme.

Review of the electronic medication management system, storage of medicines and the medication round evidenced compliance with legislative requirements, regulations and guidelines. There is evidence of the three-monthly medication reviews being completed by the general practitioner or nurse practitioner. These reviews are completed more frequently if required.

There is a registered food control plan that meets legislative requirements. Nutritional guidelines and advice are available which is appropriate for this service setting. The menu plans have been reviewed by a dietitian and are suitable for older people and/or young persons with long-term chronic health needs. The menus are clearly documented and displayed daily. The individual dietary needs are identified during the assessment process for each resident and choices are provided. Residents interviewed confirmed their satisfaction with the food service.

Safe and appropriate environment

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

There is a current building warrant of fitness. A planned, preventative and reactive maintenance programme is in place that complies with legislation and includes equipment and electrical checks.

The facility has 27 single rooms which are fit for purpose. Each room has sufficient heating, external light and ventilation. Currently all rooms are occupied by residents.

The facility has five rooms with ensuite toilet facilities and all rooms except one have handbasins. Communal bathroom and showering facilities are provided throughout the facility. Residents' rooms are spacious enough to allow for staff assistance and the safe and easy use of mobility aids where required. There is a main lounge area, two dining rooms and external areas with seating and shade.

The facility has a call bell system for residents to summon help, when needed, in a timely manner. Essential security systems are in place to ensure resident safety with six monthly trial evacuations undertaken.

There are documented and implemented policies and procedures for cleaning and waste management. Staff receive training to ensure the safe handling of waste and hazardous substances and are familiar with the requirements for safe handling.

There was evidence sighted of: sluice facilities, cleaning and laundry; safe storage of equipment; and correct use of protective equipment and clothing. All laundry services are undertaken on-site. Cleaning and laundry services are monitored through the internal audit programme.

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.

Cornwall Rest Home has a restraint minimisation and safe practice policy that includes a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and an enabler register. There were no residents requiring restraints or enablers at the time of audit. Staff are trained in restraint minimisation and restraint competencies are current.

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.

There is an infection control programme that complies with current best practice. The full time registered nurse is the dedicated infection control nurse who has a role description. The infection control programme is reviewed annually. Infection control education is provided at orientation and incorporated into the annual training programme. Training records were sighted. Records of all infections are kept; monthly data is collated, analysed and information and any trends are reported to staff.

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	39	0	5	1	0	0
Criteria	0	87	0	5	1	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	There are implemented policies and procedures to ensure that services are provided in a manner that is consistent with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). Training records confirm that staff receive education on the Code as part of orientation and the mandatory education programme. Staff interviews confirmed their understanding of the Code and their obligations. Evidence that the Code is implemented in their everyday practice includes maintaining residents' privacy; providing residents with choices; encouraging independence; involving residents and family in decision making and ensuring residents can continue to practise their own personal values and beliefs. Residents and family interviews, resident survey feedback and observation confirmed that services are provided in a manner that upholds resident dignity and maintains their privacy. Staff were observed interact respectfully with residents and their families. Interviews confirmed that communication was appropriate, and residents receive information relevant to their needs.
Standard 1.1.10: Informed Consent	FA	The organisation has an informed choice and informed consent policy that provides guidance for staff to ensure that residents are given the opportunity to be involved in the making of decisions that affect their

Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.		lives. The policy describes how consent may be obtained, provides for recording advance directives and allows for the resident's right to withdraw consent. The resident admission pack provided on admission includes consent forms such as: consent to share information with identified people and general consent to care, which the RN discusses with residents and their families during the admission process to ensure understanding. Staff interviews confirmed that they: are aware of the informed consent process; ensure that residents are fully aware of treatment and interventions planned for them; include the resident and/or family in the planning of care; and ensure informed consent is obtained before any treatment or intervention. Residents' files and interviews confirmed that informed consent is obtained. There is an advance directive policy to ensure that residents who are legally competent to make an advance directive have their wishes honoured. The policy provides a definition, the procedure for obtaining an advance directive and who may or may not make an advance directive. File reviews demonstrate that for one of six resident files an advance directive was completed and that this was in accordance with policy.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There is a policy and procedure for staff to follow, that recognises the rights of all residents to have an advocate or access advocacy services and have a right to express views about their situation without fear of reprisal. It includes giving residents and where appropriate their family/advocate, the opportunity to be involved in decisions ensuring that they are aware of the availability of advocacy services. Information regarding the availability of the Nationwide Health and Disability Advocacy Service is provided in the resident admission booklet. A retired general practitioner regularly visits the residents socially and provides support and advocacy if required. Additional information about local advocacy services are also available in the resident lounge. The complaints policy confirms residents' right to advocacy when making a complaint. Family and resident interviews confirmed that the facility provides opportunities for the family to be involved in decisions and that they are aware that advocacy services are available.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and	FA	The facility has a visiting policy that welcomes visitors, especially family and friends, at any time. Visitors can access the facility after the doors are locked using the bell at the entrance. Observation and resident and staff interviews confirmed that residents may have access to visitors of their choice at any time. Observation and interviews confirmed that families were made to feel welcome in the facility. Residents including younger persons, are encouraged to maintain linkages with family and social

their community.		networks. Resident interviews confirmed that residents including younger persons are encouraged to be involved in community activities and are free to leave the facility when they so choose, for example, to attend local club events; social functions and family outings.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is an implemented complaints policy and procedure that is in line with the Code and includes timeframes for responding to a complaint. The resident welcome pack outlines the Code, how to make a complaint to the Health and Disability Commissioner and includes the facilities complaint procedure and complaints form. The complaints and compliments procedure, that includes the compliments/complaint form, is available in the facility lounge. The manager interview and resident meeting minutes confirm that the complaints process is explained and discussed at resident meetings. A complaints register is in place and the register includes: the date the complaint is received and acknowledged; the source of the complaint; a description of the complaint; the investigation; any changes implemented and the date the complaint is resolved. There had been six verbal complaints/concerns documented since the previous audit and no written complaints. Complaints reviewed indicated that complaints are investigated promptly, and issues are resolved in a timely manner. The manager is responsible for managing complaints. Residents and family interviews confirmed that they were aware of a complaints process and would feel comfortable to make a complaint if needed. They confirmed that issues raised are dealt with effectively and efficiently. There have been no complaints lodged with the Health and Disability Commissioner or other external authorities since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents and their families are provided with information about the Code on admission in the resident welcome pack booklet. As part of the admission process, the registered nurse (RN) or the manager discuss and explain the Code to ensure understanding. The booklet provides information on the complaints process and advocacy service including in relation to a complaint. The Code and associated information is also available in brochures which are displayed in the facility lounge and are available to take away and read in private. Resident meeting minutes demonstrate that a right from the Code is discussed and explained at each resident meeting. Information on the Code is also displayed in posters in English and te reo Māori. Resident and family interviews confirmed that they are provided with information on their rights and are aware that they can access advocacy services. The resident admission agreement describes for the resident and family, the

		services provided under the agreement and those that may incur additional charges.
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 organisation has a policy and procedure that is aligned to the requirements of the Privacy Act and Health Information Privacy Code and ensure that all residents will be treated with respect and dignity and their privacy and independence will be preserved. Resident, family and staff interviews, resident survey results and observation confirmed that staff knock on bedroom doors prior to entering rooms and ensure doors are shut when cares of a personal nature were being provided. Residents and families stated that conversations of a private or personal nature were held in the resident's room and not in public areas and that resident privacy is respected. The organisation has a sexuality policy to ensure that a resident's intimacy and sexuality are appropriately managed to ensure a resident's rights are protected and the rights of other residents and staff are not compromised. It includes: assessing and identifying resident needs; and responding to expressions of sexuality. Interviews and observation confirmed that residents were able to wear their preferred choice of clothing, makeup and personal adornments. There is a neglect and abuse policy and procedures to ensure that residents will be protected against all forms of abuse or neglect and that it will be managed promptly, professionally and with respect. Staff receive training on abuse and neglect and are aware of their obligations to report any incidences of suspected abuse. There are no documented incidents of abuse or neglect. Staff, resident, and family interviews confirmed that there was no evidence of abuse or neglect. Resident files, including files for younger persons under 65, and interviews confirmed that cultural and/or spiritual values and individual preferences are identified and upheld.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The organisation has a Māori health plan that acknowledges the Treaty of Waitangi and aims to eliminate barriers to access for Māori. It describes how the values, beliefs and cultural practices of residents identifying as Māori will be maintained. There is also a cultural safety policy that describes for staff the procedure for delivering culturally competent services. Support for staff in providing culturally appropriate care, and for Māori residents and their families, can be sourced if required. Staff receive training in cultural safety as part of the mandatory annual education module. There were two residents identifying as Māori at the time of audit. A review of residents' files confirmed that specific cultural needs are identified in the residents' care plans. Staff interview confirmed that they were aware of the importance of the involvement of whānau in the delivery of care for Māori residents and how culturally competent services are delivered.

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	Residents' files reviewed demonstrated that information gathered during assessment that includes a resident's specific cultural needs, spiritual values, and beliefs. Cultural needs identified in these assessments are addressed in care planning (refer 1.3.7.1). Staff, resident and family interviews confirmed that residents are provided with choices regarding their care and the services provided, and that residents and family are involved in the assessment and the care planning processes (refer to 1.3.8.2). Resident and family stated that they felt services were responsive to individual resident's cultural needs. Residents who wish to attend church services can do so within the community. A local catholic priest or lay person visits the facility approximately every four weeks to provide communion to residents who wish to receive this.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There is policy and procedure to ensure that residents are free from any discrimination, coercion; harassment; or exploitation for residents. It outlines for staff how this will be prevented and reported. Job descriptions describe the personal qualities expected of the position including honesty, integrity, and awareness of ways to optimise independence. Resident and family interviews confirmed that staff maintain appropriate professional boundaries. There were no complaints recorded in the complaints register relating to any form of discrimination, coercion, harassment or exploitation or abuse and/or neglect. This was confirmed in staff interviews.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Policies and procedures are current and available to staff (refer to 1.2.4.3). There is a training programme for all staff. Interviews and training programmes reviewed, confirmed that staff have access to and are encouraged to complete the Wairarapa District Health Board (WDHB) online training. Resident and family interviews stated that they were very satisfied with the standard of care provided. The nurse practitioner (NP) interviewed stated that there were no issues with the care provided.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	There is an open disclosure policy that provides the procedure for staff to ensure there is open disclosure of any harm or incident affecting the resident or an error that has affected the resident's care but does not appear to have caused harm. Completed incident forms and resident records demonstrated that family are informed if the resident has an incident/accident; a change in health or a

conducive to effective communication.		change in needs. Family contact is recorded in the resident's file and on the incident form. Family and resident interviews confirmed that family are informed of any changes in resident status and that they are invited to care planning meetings for the resident (refer to 1.3.8.2). Family confirmed they are welcome to attend the residents' meetings if they wish. Family, residents and staff interviews confirmed that the environment was conducive to effective communication for all including younger persons. There are policies to ensure that where required, interpreter services will be provided to ensure effective communication with a resident who primary language is not English. Interview with the manager confirmed that these would be accessed through the WDHB, if required. At the time of the audit there were no residents who required an interpreter.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Cornwall Rest Home is owned and managed by a managing director (manager). The facility has a strategic plan which documents the mission, values, and scope of the facility. The plan defines the behaviours, expected outputs and critical success factors for the organisation and reflects a person-centred approach. The facility's mission statement, philosophy and values are detailed in the resident welcome pack provided to new residents and family on admission. These are documented for staff in operational documents. The manager monitors and analyses operational activity and trends. The manager is suitably qualified and experienced with a diploma in finance and a diploma in human services. The manager has recent experience as the chief executive officer of a disability service and experience in financial planning and life insurance. Prior to this the manager was a registered nurse (RN) and maintained a practising certificate until 2005. The previous owners provided an induction and orientation for the manager appropriate to the role nine months ago and have been available to support the organisation since. One previous owner visited the facility on both days of the audit. The manager is supported by an office administrator who has been in the role for 14 years and a RN, who was employed by the facility for 10 years prior to becoming a RN about four years ago. The RN works Tuesday to Friday inclusive and is responsible for clinical management and oversight of services. Another part-time RN who has been with the facility for over four years works on Mondays. Cornwall Rest Home is certified to provide rest home level care and currently provides care for up to 27 residents. The facility also holds WDHB contracts for long-term support for chronic health conditions (LTSCHC), respite care and day care. On the first day of audit there were 27 beds occupied. Occupancy included two residents under the respite care contract requiring rest home level care and one resident under the LTSCHC who was under the age of 65. There were seven people under the day care contract at the time of 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 a temporary absence of the manager, the RN is responsible for the day to day operation of the service and is supported by the office administrator. In the absence of the RN, the second part time RN would ensure continuity of clinical services with the support and help of the previous owner/manager.
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	Cornwall Rest Home has a documented quality and risk management framework that is available to staff, to guide service delivery. Policies are current, align with the Health and Disability Sector Standards and reflect accepted good practice guidelines, except for observations following an unwitnessed fall (refer to 1.2.4.3). New and revised policies are presented to staff on the notice board to read and sign to evidence that they have read and understood the policy. Staff confirmed that they are made aware of updated policies. The service delivery is monitored through a number of clinical indicators such as: complaints; incidents and accidents; falls; wounds; and medication errors. There is evidence that the annual internal audit programme is implemented as scheduled. Quality improvement records provides evidence that data is being collected, collated and analysed to identify trends. Where required, corrective action plans are developed, implemented and evaluated. Corrective actions from all quality initiatives such as a review of incidents and internal audits are maintained on one corrective action log. There is communication with staff of any subsequent changes to procedures and practice through meetings. Residents and family are notified of updates through the facility's monthly resident meetings. A review of resident meeting minutes demonstrate that meetings include but are not limited to: a manager's update; the menu; activities; feedback; complaints; residents rights; complaints process; health and safety and internet use. Meeting minutes and resident and family interviews confirmed opportunities for participation in decision making and contributing to quality improvements for all residents. There is a residents' committee, elected by other residents and resident input in in quality and risk management. This includes being involved in the recruitment of new staff, providing input into staff appraisals and representation on the facility health and safety subcommittee. Monthly quality and staff meetings evidenced all aspects of quality improvement, risk management and that clinical indicators are discussed. Staff reported that they are kept informed of quality improvements. Satisfaction surveys for residents and family are completed as part of the internal audit programme. The

		survey results for October 2018 reviewed evidenced satisfaction with services provided and this was confirmed in resident and family interviews. The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. Health and safety audits are completed as part of the annual internal audit programme and a monthly environmental inspection and health and safety check list completed. There is a nominated health and safety representative and interview confirmed an understanding of the obligations of the role. The health and safety is discussed at a subcommittee of the monthly quality meeting. There is evidence that identified hazards are reported as an exception report through the electronic reporting system. A current hazard register is available which is reviewed and updated annually or when a new hazard is identified.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	PA Moderate	The manager and RN are aware of situations which require the facility to report and notify statutory authorities, including unexpected deaths, police involvement, sentinel events, infectious disease outbreaks and changes in key management roles. Since the previous audit the facility has reported the removal of the second director to the Ministry of Health. There is policy to guide staff in reporting advents and an implemented accident/incident reporting process that includes electronic reporting of accidents/incidents. Staff receive education on the accident/incident process as a component of orientation and staff training programme. Staff interviews, and review of documentation evidenced that staff document adverse, unplanned or untoward events through the online electronic application. These are reviewed and signed off by the manager. Incident/accident records were reviewed demonstrated evidence of a corresponding note in the resident progress notes and notification of the resident's next of kin where appropriate. Where a resident had experienced an unwitnessed fall there was observations for an altered level of consciousness that had been documented, however, the altered level of consciousness observations were not consistently completed within the timeframes specified in policy. There was no evidence that neurological observations were completed or that reassessment had occurred following an unwitnessed fall. Accident/incident data is analysed and specific learnings and results from accidents/incidents inform quality improvement processes and are regularly shared at monthly meetings.
Standard 1.2.7: Human Resource Management Human resource management	FA	Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position is documented in job descriptions. Staff files reviewed demonstrate that recruitment processes for all staff include: a signed employment

processes are conducted in accordance with good employment practice and meet the requirements of legislation.		agreement; position specific job description; and police vetting. Current copies of annual practising certificates and registrations were evidenced for all staff and contractors that require them. An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency, including completing personal cares. Care staff confirmed their role in supporting and buddying new staff. The organisation has a documented mandatory education and training schedule. There are systems and processes in place to ensure that all staff complete their required training and competencies. In addition to education provide internally, staff are also supported to complete relevant online education web-based training modules provided through WDHB. Individual staff attendance records and education session attendance records evidenced that ongoing education is provided. One of the two RNs has completed interRAI assessments training and competencies and has recently completed refresher training. Annual competencies are completed by care staff, for example: hoist use; hand washing; medication management; and moving and handling. All staff including RNs have undertaken at least eight hours education and training hours per annum. An appraisal schedule is in place and all staff files reviewed evidenced current staff appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The facility has rostering policy that provides guidance to ensure that there is an appropriate skill mix to provide safe and quality care to meet the needs of residents. Rosters are based on a six-week schedule made available to staff at least two weeks in advance. Staffing levels are reviewed to accommodate anticipated workloads and the appropriate skill mix required to meet resident acuity and the number of residents. There are sufficient RNs and caregivers, available to be rostered, to accommodate increases in workloads or unanticipated staff leave. There are 25 staff, including the manager, administration, RNs, recreation staff, cooks, casual/part time staff who provide cover over tea times and a cleaner. Rosters reviewed evidenced staffing levels were sufficient to meet the needs of residents. A RN is on duty eight hours a day Monday to Friday and the manager and RN are on call after hours, seven days a week. The RN is supported by adequate levels of care staff. There is always at least one staff member on duty with a current first aid certificate and one who is certified as medication competent. Observation of service delivery confirmed that resident needs were being met in a timely manner. Residents and family interviews stated that staffing is adequate to meet the residents' needs and staff confirm that whilst busy, they have enough time to complete their scheduled tasks and resident cares.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The facility has policy and procedure to guide staff in the use of the resident information management system. All resident information is maintained in a separate uniquely identifiable record and this includes information obtained on admission, with input from the resident and/or resident's family where applicable. There are policies and procedures in place to ensure privacy and confidentiality of resident information. Staff interviews confirmed the awareness of obligations and procedures for maintaining confidentiality of resident information. Resident care and support information is maintained electronically and can be accessed in a timely manner and is password protected from unauthorised access. Some historical hard copy information and archived records are secured in a locked in a cabinet, in a locked office. Archived records are easily retrievable. Documents containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. The facility has recently implemented an electronic computer-based person-centred software system to maintain and a mange resident information. Resident files and care notes are recorded and monitored through this system allowing integration of resident files with any relevant exception reports such as accidents/incidents. The clinical records are integrated, including information such as medical notes, assessment information and reports from other health professionals. Electronic medication charts are kept separate from residents' files and are accessible by authorised personnel only. Information, including progress notes, is entered into the resident record in an accurate and timely manner and identifies the name and designation of the person making the entry. Residents' progress notes are completed at least once every shift. Entries made by the service providers in the progress notes identify the name and designation of the person making the entry.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Resident files reviewed evidenced signed admission agreements. Service charges comply with contractual requirements. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The service communicates with needs assessors, general practitioners (GP) and other appropriate agencies prior to the resident's admission regarding the resident's care requirements. Residents and family members interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.

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 policy that describes guidelines for discharge, transfer documentation and follow-up. Interview with the RN confirmed all relevant information is documented and communicated to the receiving health provider or service via the yellow envelope system. A transfer form accompanies residents to receiving facilities. A copy of the record is kept on the resident's file. Follow-up occurs to check that the resident is settled, or in the case of death, communication with the family occurs.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	There are policies and processes for medication management that align with accepted guidelines. Review of the medication areas evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Weekly temperature checks of the medication fridge evidence temperatures within the recommended range. A computerised medication management system is used at the facility and meets current legislation and safe practice guidelines. The medication round was observed at lunch time and evidenced safe practice meeting the requirements of the standard. All staff authorised to administer medicines have current competencies. Administration records are maintained, as are specimen signatures. Staff education in medicine management is provided. The medicines register is maintained and evidenced weekly checks and six-monthly physical stocktakes. However, the process for checking in these medicines does not consistently comply with legislation, protocols and guidelines. Residents' who request to self-administer medicines are provided with secure storage for their medicines. An initial assessment to verify the resident's safety and competency to administer medicines is completed by the GP or NP. Three-monthly competency assessments are recorded for one resident who is self-administering medication. The resident is checked for having taken their medicines.
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 manager oversees food provision at the facility. There is an open plan kitchen with all food prepared and cooked on site. The cook manages the food service and is supported by a second cook. Kitchen staff have current food safety training. Observation indicated the kitchen and equipment are well maintained. Food safety information and a kitchen manual are available in the kitchen. Registration of the food control plan had been completed. There is a scheduled verification due for the food control plan. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Special equipment to meet residents' nutritional needs was sighted.

		There is a four weekly seasonal winter and summer menu which has been reviewed by a dietitian. The service encourages residents to express their likes and dislikes. At interview, the cook reported that the RN completes each resident's nutritional profile on admission with the aid of the resident and family. There were current copies of the residents' nutritional profiles located in the kitchen. The kitchen can cater to specific needs as requested and diets are modified as required. Interview with the RN and cook confirmed high protein drinks are supplied for those residents identified as being at risk of weight loss. Residents requiring extra support to eat and drink are assisted and this was observed during the on-site audit. Food is served to the dining rooms and a tray service is available if requested. Records of temperature monitoring of end cooked food, fresh and frozen food on arrival, refrigerators and freezers are maintained as per the food control plan and are within accepted range. Electrical testing and tagging noted in relation to kitchen equipment had been completed. Food audits are carried out as per the annual audit schedule. A cleaning schedule is maintained. Interviews with residents and families confirmed their satisfaction with the quality of 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 service has a process in place where access is declined, should this occur. Records of enquiry are maintained and in the event of decline, information is provided regarding alternative services. When residents are declined access to the service, residents and their family, the referring agency, the GP and/or the NP are informed of the decline to entry and the reason for declining services. The residents would be declined entry if not within the scope of the service or if a bed was not available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Policies and protocols are in place to ensure continuity of service delivery. InterRAI assessments are completed within three weeks of admission and six-monthly thereafter, reflecting data from a range of sources, including: the resident; family; GP/NP; and specialists as applicable. Review of wound care documentation evidenced all wounds, including skin tears, are recorded on wound care plans. Residents interviewed confirm assessments are conducted according to their needs and in a private manner. Interviews with residents and family confirmed their involvement in the assessments.
Standard 1.3.5: Planning	FA	Long-term care plans are developed with the resident. Family/whānau involvement is included where appropriate. Short-term care plans are developed for the management of acute problems, when

Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.		required, and signed off by the RN when problems are resolved. Interview with residents and staff; review of nursing progress notes and monitoring records confirmed continuity of service delivery. Interviews with staff and review of medical and nursing care notes evidenced any instruction by the GP or NP was followed and implemented. Interviews with residents confirmed they have input into their care planning and that the care provided meets their needs.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	In files sampled, wound care plans, nutrition management, skin integrity management, medical specific plans, pain management and falls prevention plans were evident. The use of short-term care plans was evident where required. Nursing care notes and observation charts are maintained (refer to 1.2.4.3). Family communication is recorded in the residents' nursing care notes. The residents' primary care is provided by their own GP or the NP. The NP interviewed stated the facility applied changes of care advice immediately and was complimentary about the quality of the service delivery provided. Residents can choose their own GP. There is evidence of referrals to specialist services such as podiatry, physiotherapy, dietitian and specialist nurses. There were sufficient supplies of products and equipment seen to be available that complied with best practice guidelines and met the residents' needs. Staff interviews confirmed they are familiar with the needs of the residents they are allocated to. The care being provided is consistent with the needs of the residents as evidenced by discussions with residents, family and staff.
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.	PA Low	The recreation office (RO) is responsible for the activities programme and has a bachelor's in counselling and a master's in education. A current monthly calendar is displayed on noticeboards throughout the facility for all residents and their families/whānau to view. Individual and group activities, and regular events are offered. Regular exercises and outings are provided for those residents able to participate. The RO confirmed they facilitate activities of choice when there are specific needs for younger persons with long-term chronic health conditions. The activity programme includes input from the local community and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations. The residents' attendance at each activity is recorded in the care notes of an electronic patient management system which also records a subjective response at the time of the activity for example; use of a symbol recognising a response to the activity the resident participates in. However, there is no documented evidence to confirm activity requirements appropriate to residents' needs, age or culture is fully

		assessed to inform the activities programme. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge. Residents can join in with any activities. Interviews with residents and families confirmed they are satisfied with the activities provided and that specific needs for younger residents with long-term chronic health conditions were met
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessments, or when a residents' needs change. Evaluations are carried out by the RN with input from the residents, family, caregivers, physiotherapist and the GP or NP. Residents and families interviewed confirmed their participation in care plan evaluations. However, there is no evidence formal care plan evaluations are documented or indicate progress towards meeting the goals or desired outcome. There is no sign off by the resident, family or RN. Resident care is evaluated on each shift and reported in the residents' nursing care notes. If any change is noted, it is reported to the RN. A short-term care plan is initiated for short-term concerns, such as but not limited to infections and wound care. There are three-monthly reviews or sooner by the GP or NP. Review of resident records and interviews with residents and family/whānau verified they are kept informed of all changes.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. If the need for other non-urgent services are indicated or requested, the GP, NP or RN sends a referral to seek specialist service provider assistance from WDHB. Referral forms and documentation are maintained in resident files. Referrals are followed up on a regular basis by an RN, NP or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from	FA	Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements for the storage of chemicals and hazardous substances that comply with legislation, including the requirements for clear labelling and storage of chemicals and the disposal of and collecting waste. The hazard register is available and current. Current material safety data sheets are available in the kitchen and accessible for all staff. Staff receive

harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		training and education in safe and appropriate handling of waste and hazardous substances. Personal protective clothing and equipment is provided and available, such as aprons, gloves and masks that is appropriate to the recognised risks. Protective clothing and equipment were observed to be used in high-risk areas.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed in the entrance to the facility. The manager is responsible for maintenance. The manager has identified refurbishment requirements and has an implemented planned and reactive maintenance schedule. The facility has an annual test and tag programme, and this is up to date, with checking and calibrating of clinical equipment annually. Staff interviews and facility inspection confirmed there is adequate equipment to support care for all residents including younger people. Younger residents' personal equipment is not used for other residents. Each resident has their own room with sufficient space to sit and read or when required. There are external landscaped lawns, decked areas with outdoor tables and chairs, and shade able to be accessed freely by residents and their visitors.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are sufficient numbers of accessible toilets and showering facilities of appropriate design to meet resident needs located in each wing of the facility. Communal toilets have a system to indicate vacancy and have disability access. The visitor/staff toilet is located near communal areas. Five rooms have ensuite toilet facilities and all rooms except one have a wash basin. All shower and toilet facilities have: call bells; and sufficient room; approved handrails; and other equipment to facilitate ease of mobility and independence. Residents were observed being supported to access communal toilets and showers in a manner that was respectful and preserved resident dignity. Hot water temperatures are monitored three monthly and were noted to be maintained within recommended temperature ranges. Manager interviews confirmed that where these varied from the recommend range corrective actions were taken immediately to address this.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with	FA	All residents have their own rooms and each is of sufficient size to enable residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Resident interviews and observation confirmed that there was enough space to accommodate furniture; equipment; and staff as

adequate personal space/bed areas appropriate to the consumer group and setting.		required. Residents and their families are encouraged to personalise their rooms. Residents' rooms viewed were personalised with their own furniture; possessions and memorabilia. There are designated areas to store equipment such as mobility aids, wheel chairs and walking frames safely and tidily.
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	The facility has: two dining rooms; a main lounge and a small communal lounge outside one room. The two dining rooms can service as lounge areas outside meals times. There are external balconies around the veranda of the facility and other areas with seating and shade that can be easily accessed by residents, including younger people, to find privacy. Residents can also meet with visitors in their room for privacy if they wish. Furniture in residents' rooms includes residents' own personal pieces; is appropriate to the setting; and is arranged in a manner that enable residents to mobilise freely. The lounge areas are used for activities. Residents are encouraged to have meals with other residents in communal dining rooms, however, can choose when and where to have their meals.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	PA Low	All resident and facility laundry is undertaken on-site at the facility by caregivers. This includes laundering of residents' personal clothing. There are processes in place for the daily collection, laundering and return of linen and residents' personal clothing. There are two separate rooms, one for clean and one for dirty linen which provide clear delineation of clean and dirty areas which was observed to be maintained. Both areas were observed to be compact, each containing a large industrial laundry appliance. There area had space for one person at a time in the room to undertake duty laundry activities. Caregivers who undertake laundry duties, also provide resident cares and may also assist with resident meals. Laundry functions, washing and drying, were observed to be occurring throughout the audit. Interview and observation confirmed that there was clear delineation of roles and use of personal protective clothing and equipment when providing cares and undertaking laundry. There is a cleaner on duty for five hours per day Monday to Friday. Caregivers undertake essential cleaning duties if required over weekends. Cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. However, cleaning products were not always stored as per policy. The effectiveness of cleaning and laundry processes are monitored through the internal audit process

		with no significant problems identified. Resident interviews and observation noted the facility to be clean and tidy.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	Staff files and training records demonstrate that orientation and training include emergency procedures and fire safety. An approved fire evacuation plan was sighted that is relevant to the configuration of the facility. Interviews and documentation confirmed that fire drills are conducted at least once every six months. There is firefighting equipment and signage displayed. The most senior person on duty is the nominated fire warden for the facility. Registered nurses, most caregivers, the cook and activities person have completed first aid training. There is a least one staff member on each shift with a current first aid certificate. There are supplies to sustain staff and residents in an emergency situation including alternative energy and utility sources available in the event of the main supplies failing. These include a barbeque and gas bottle; lighting; food, and continence supplies. A generator can be sourced externally if required. The facility has an external tank of water for emergencies, however, sufficient fresh water to support residents and staff for the required seven days in an emergency could not be assured. There are call bells to summon assistance in all resident rooms, toilets and communal areas. Call bells are checked three monthly and there are randomised weekly audits of call bell response times. Observation on the days of the audit and resident and family interviews confirmed that call bells are answered promptly. There are security systems in place to ensure the protection and safety of residents, visitors and staff. The facility is locked in the evenings and external doors are locked. Doors are checked by staff late afternoon. The entrance is monitored by an external camera. There is night time security lighting in place. A security company periodically patrols the facility grounds in the evenings. Caregivers carry the facility mobile phone at night and manager interview advised that police would be called at night if staff were concerned about their security.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment	FA	All resident rooms and communal areas accessed by residents have safe ventilation and at least one external window providing natural light. There are wall panels for heating in residents' rooms. There are two heat pumps in communal areas. The environment in both residents' rooms and communal areas was noted to be maintained at a satisfactory temperature. Resident meetings provide a forum for resident feedback on the comfort and temperature of the

that is maintained at a safe and comfortable temperature.		environment. Resident and family interviews confirmed that their environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility. There are two external designated smoking area for residents that ensure smoking does not impact on other residents or staff. There are two residents who smoke.
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	The RN is the designated infection control nurse (ICN) with support from the manager, GP, NP and the infection control team. There is a signed infection control nurse job description outlining responsibilities of the position. The ICN is aware of processes for the required notification of infection control related issues. There is evidence clinical indicator data on infection related issues are included in monthly quality assurance meetings and communicated to staff. Cornwall Rest Home has an infection control programme which is reviewed annually. The infection control programme's content and detail are appropriate for the size, complexity and degree of risk associated with this service. The programme is linked into the incident reporting system. The facility provides an environment that minimises the risk of infection to residents, staff and visitors through the implementation of the infection prevention and control programme. Hand sanitizers and gels are available for staff, residents and visitors to use. Audits are conducted and include hand hygiene and infection control practices. Staff interviewed demonstrated knowledge of the infection prevention and control programme and practices.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The ICN is responsible for implementing the infection prevention and control programme. Infection control is a standard agenda item at the facility's quality assurance meetings. The ICN has access to external infection control specialist advice if required. The ICN is aware of the need to analyse data and the reasons behind this. Staff are made aware of residents' infections through staff handovers, short-term care plans and residents' nursing care notes. The ICN has access to all relevant infection control resident data to undertake surveillance, internal audits and investigations. Observations during the on-site audit confirmed implementation of infection prevention and control procedures such as hand washing and the use of antibacterial hand gels.
Standard 3.3: Policies and procedures	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, training and education of staff. The infection

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.		control policies link to other documentation and includes references where appropriate. Staff were observed to follow the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and the location of infection control policies and procedures.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The ICN receives ongoing education and has completed a study day at the WDHB in 2019. The ICN ensures training is provided to staff. Staff completed formal education via orientation and as part of the annual education provided and by way of live webinars. Informal education is provided and includes, but not limited to, hand hygiene and standard precautions. Training on infection control has been provided in 2019. Resident education occurs on admission and as part of providing daily cares.
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 surveillance is appropriate for the size and complexity of services provided. Infection data is collected and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. This data is reported to the monthly quality assurance meeting. Meeting minutes is available for staff. Infection control alerts were documented on the individual residents' records reviewed. All staff are required to take responsibility for surveillance activities. Interviews with staff reported they are made aware of any infections of individual residents by way of feedback from the RN, verbal handovers and nursing care notes. This was evidenced in handover observed and review of the residents' files. There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Cornwall Rest Home has a philosophy that restraint is considered as a last resort. The definition of restraint and enabler is congruent with the definition in the standard. There were no residents using an enabler or restraint on the days of the audit. Staff and management interviews confirmed the approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Incident/accident records demonstrated evidence that accidents/incidents are reported through an electronic online application, documented in the resident progress notes and the resident’s next of kin were notified where appropriate. The falls prevention policy, which has been approved by the facility’s general practitioner, requires that altered level of consciousness observations be undertaken within specified timeframes for residents experiencing a head injury or unwitnessed fall. The assessed altered level of consciousness was rated on a range from alert to unresponsive. This policy and tool replace neurological observations in the falls policy which has been updated since the previous audit and does not reflect current best practice. Documentation for 15 unwitnessed falls was reviewed. Ten of fifteen did not evidence that the altered level of consciousness had been documented consistently within the required timeframes. The service has been working with staff through team meetings and regular training to improve the recording of altered level of consciousness. The file sample for residents with recent unwitnessed falls was extended by	i) Altered level of consciousness observations are not completed within the timeframes specified in policy. ii) Neurological observations are not included in policy and are not completed for unwitnessed falls.	i) Monitoring should occur as specified in policy. ii) Review policy to include accepted best practice in regard to management of a resident with a potential/suspected head injury to mitigate the risk to safety, and prevention of delays in timely referral of the resident.

		three to review the use of altered level of consciousness tool and the required checks in place. Review of three falls identified the required altered level of consciousness checks were not consistently documented as per policy. Documentation for 18 of 18 unwitnessed falls reviewed had no evidence of other assessment, including but not limited to, vital signs or neurological observations taken to aid early detection of warning signs.		90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	There are policies and processes describing medication management which align with accepted medicine legislation, protocols and guidelines. Residents' regular medication is checked against the resident's medication profile on arrival from the pharmacy by a RN. Review of the medicines register identified medicines requiring two signatures are signed for on arrival by an employee without current medication competency.	The process for checking in of medicines that require two signatures does not comply with legislation, protocols, and guidelines.	Ensure the process for checking in of medicines that require two signatures complies with legislation, protocols, and guidelines. 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	Interview with the RO confirmed they plan and implement the activities programme. The RN completes a social profile on admission. In all residents' files reviewed the activities section of the care plans reflected the resident's interests and activity preferences. Interview confirmed the RO does not view the care plan. Interviews with staff confirm the activities programme is developed via enquiry with residents about their individual needs and in feedback received in resident meetings. Residents' meeting minutes evidenced residents' involvement and consultation of the planned activities programme. Staff confirmed every effort is made to identify and facilitate meaningful activities. However, six of six files reviewed did not contain documented evidence to confirm all resident needs, for example; cognitive, physical, social and individual needs, in relation to activity requirements are fully assessed to inform the activities the activities programme.	Files reviewed did not evidence the residents' activity needs were fully assessed to inform the activities programme.	Provide evidence to confirm all residents'; cognitive, physical, social and individual needs are fully assessed and inform the activities programme. 90 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	Long-term care plans are updated six monthly. Six monthly formal care plan evaluations in six of six resident files reviewed did not document the formal evaluation or sign off. There is no evidence to indicate progress or the degree of achievement towards meeting desired goals and outcomes.	Formal LTCP evaluations are not documented to record evidence of progress or achievement against goals and desired outcomes and are not signed off by the RN, resident or family/whānau.	All care plan evaluations to be formally documented, signed off and are to include progress or the degree of achievement against goals and desired outcomes. 90 days
Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.	PA Low	There is policy to ensure the safe storage of cleaning products. The cleaner stores chemicals on a trolley when cleaning and the trolley is kept with them at all times when in use. There is a separate designated locked cupboard for the safe and hygienic storage of cleaning equipment and chemicals. Kitchen cleaning products are also stored in the kitchen. However, observations throughout the audit identified the cleaning cupboard was left unlocked when unattended and cleaning products in the kitchen were not stored in a locked cupboard.	Cleaning chemicals in the kitchen and cleaning cupboard were not stored securely.	Ensure that all cleaning products and chemicals are stored securely and unable to be accessed by residents or visitors. 90 days
Criterion 1.4.7.4 Alternative energy and utility sources are available in the event of the main supplies failing.	PA Low	Supplies to sustain staff and residents in an emergency situation include for example, lighting; continence supplies; cooking facilities and fresh, dehydrated and frozen food. Emergency water can be sourced from an external storage tank. However, there were no records of when the water had been replenished. The 3,200 litres did not meet the Wellington Regional Emergency Management Office's recommended quantity for the number of residents and staff.	There was insufficient evidence of fresh water to support residents and staff for the required seven	Ensure that the facility has access to sufficient fresh water in the advent of an emergency.

			days in an emergency.	90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.