

# Hardwill Group Limited - The Lodge

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## 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 The DAA Group 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>	Hardwill Group Limited
<b>Premises audited:</b>	The Lodge
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services - Psychiatric; Residential disability services – Sensory
<b>Dates of audit:</b>	Start date: 11 November 2020      End date: 12 November 2020
<b>Proposed changes to current services (if any):</b>	The proposed building of an 84-bed complex on adjoining land has not yet commenced. A request for six additional dual rest home and hospital beds to replace six of the current rest home beds had been

made through HealthCERT. Review of the suitability of rooms for this purpose was undertaken during this audit. Five additional rooms only are considered suitable as detailed in outcome 1.4, in particular criteria 1.4.3.1 and 1.4.4.1.

**Total beds occupied across all premises included in the audit on the first day of the audit: 30**

# 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

The Lodge is a facility on the outskirts of Tauranga that is operated by the Hardwill Group Limited. Rest home and hospital level care is available for up to thirty-one residents who are on a range of different contracts. One additional room has been added since the last audit and one other modified with an ensuite added. A further five beds have been assessed as suitable for use by hospital care residents, therefore bringing the total number of dual-purpose beds to twelve, one of which is deemed to be 'medical'. The service is managed co-operatively by a manager and a registered nurse manager. Residents informed they enjoy living at The Lodge and family members were positive about the overall level of care provided.

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

This audit has resulted in one identified area for improvement relating to interRAI assessments.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services provided support personal privacy, independence, individuality and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. There are systems in place to ensure residents and family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual and individual values and beliefs are assessed and acknowledged. There was no evidence of abuse, neglect or discrimination. The service has linkages with a range of specialist health care providers to support best practice and meet residents' needs.

Residents and family members interviewed spoke very positively about the comfortable, relaxed environment and the care and support provided.

Residents are informed about how to make a complaint and are encouraged to express any dissatisfaction at regular residents' meetings. A complaints register is maintained with evidence that complaints are resolved promptly and effectively.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. In addition to receiving formal reports on a regular basis, the director has ongoing contact with the managers and meets with them formally on a monthly basis. Both the manager and the registered nurse manager are suitably qualified to manage the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. There is a systematic approach to identify and deliver a variety of ongoing training for staff, which enables them to maintain their skills and knowledge. An annual individual performance reviews is completed with each staff person. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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.
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Services at The Lodge are provided in a manner that promotes continuity in service delivery and a team approach to care delivery. All processes for assessment, planning, provision, evaluation, review and exit are provided and completed by suitably qualified personnel. Individualised care plans are completed. When there are changes to the resident's needs, a short-term plan is developed and integrated into a long-term care plan, as needed.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Residents and family/whanau expressed satisfaction with the activities programme in place.

There was a safe electronic medicine management system in use. The medicine administration system was observed at the time of audit. Staff competency assessments are maintained. The general practitioner (GP) and nurse practitioner (NP) complete three-monthly reviews or more frequently as needed.

Food services meet the preferences of residents and special diets are catered for. There is a food control plan in place.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility is an older style building, which has a current building warrant of fitness on display. Maintenance is occurring according to a schedule and repairs are being completed as needed. Electrical equipment is tested, hot water temperature checks undertaken, and medical equipment calibrated as required. Communal and individual spaces are available both inside and outside. External areas are easily accessible and provide a range of environmental options, shade and seating.

Waste and hazardous substances are managed according to requirements. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely handled and stored appropriately. Laundry is undertaken onsite and evaluated for effectiveness through the internal audit system. Daily cleaning schedules are upheld.

Staff are trained in emergency procedures and use of emergency equipment and supplies. Regular fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has access to policies and procedures that support the minimisation of restraint and describe assessment, approval, monitoring and review processes should one be used. No enablers were in use at the time of audit. One person was using an enabler and its use was described as infrequent, voluntary and for the safety of resident who chooses when to use it. Staff demonstrated knowledge and understanding of the restraint and enabler processes.



## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control management system minimises the risk of infection to residents, visitors and other service providers. Two registered nurses (RN managers) share the infection coordinator role. Documentation sighted evidenced that relevant infection control education is provided to staff.

Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## 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	44	0	1	0	0	0
Criteria	0	92	0	1	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation.	FA	The Lodge has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training is provided as verified in the training records.
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	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Clinical files sampled showed that informed consent has been gained appropriately using the organisation's standard consent form. These were signed by the enduring power of attorney (EPOA) or residents and the general practitioner or nurse practitioner make clinically based decision on resuscitation authorisation if required. Staff were observed to gain consent for day to day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have support persons.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents have visitors of their choice visit regularly. Access to the community and other mainstream supports is encouraged for all residents including young people with disability. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code and describe the purpose and use of the complaint register. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Staff are trained in complaint management during their orientation and those interviewed knew to transfer verbal complaints onto a complaint form, or to go direct to a registered nurse or manager. A complaints flow chart is available.</p> <p>The complaints register reviewed showed that eight complaints had been received since mid-May 2018, five of which were behaviour related. Complaints about one specific resident were recorded elsewhere and managed separately. Actions taken, through to an agreed resolution, are planned, documented and completed within the timeframes. Improvements have been made wherever possible. The manager and registered nurse manager are co-operatively responsible for complaints management and follow up, although include the director in discussions when relevant. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>	FA	<p>Information about consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members and residents interviewed were aware of consumers' rights and confirmed that information was provided to them during the admission process.</p>

their rights.		The information pack outlines the services provided. Resident agreements signed either by the resident or by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Young people with disabilities are encouraged to maintain their personal, gender, sexual, cultural, religious and spiritual identity. This was confirmed in interviews conducted.</p> <p>The residents' privacy and dignity were respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with residents assessed as rest home level of care, hospital level of care and young people with disabilities able to move freely into the surrounding areas and in and out of the facility with no restrictions. Records sampled confirmed that each resident's individual cultural values, religious beliefs and social needs, had been identified, documented and incorporated into their care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The RN/Manager (RN/M) and GP reported that any allegations of neglect if reported would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. Family/whanau and residents interviewed expressed no concerns regarding abuse, neglect or culturally unsafe practice.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The required policies on cultural appropriateness were documented. Policies refer to the Treaty of Waitangi and partnership principles. The Maori Health plan includes a commitment to the principles of the Treaty of Waitangi and identified barriers to access. It also recognised the importance of whanau. Assessments and care plans documented any cultural/spiritual needs. Special consideration of cultural needs is provided in the event of death as outlined in the policy. The required activities and blessings are conducted when and as required. The menu caters for cultural needs as required. Staff have received cultural awareness training. There was one resident and five staff members who identified as Maori at the time of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which</p>	FA	<p>Cultural needs at the Lodge are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members and residents interviewed confirmed they were encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans sampled.</p>

recognise and respect their ethnic, cultural, spiritual values, and beliefs.		
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Family members interviewed stated that residents were free from any type of discrimination, harassment, or exploitation and this was confirmed by the residents. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The RN/M stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through ongoing professional development of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. They complete webinar online training, attend to registered nurses study days offered by the local district health board. Four health care assistants had completed training in mental health and addiction services. Policies and procedures are linked to evidence-based practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Family members stated they were kept well informed about any changes to their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records sampled. Staff understood the principles of open disclosure, which is supported by policies and procedures.</p> <p>Staff knew how to access interpreter services if required. Staff can provide interpretation as and when needed and the use of family members and communication cards is encouraged. Strategies to promote effective communication with residents with physical and intellectual disability were in place.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate</p>	FA	<p>The Lodge is operated by the Hardwill Group, which was established in 2016 prior to the purchase of the facility. A 2020-2021 business plan outlines the scope, mission, philosophy, goals and objectives of the organisation. Key words within the mission and philosophy are about providing quality care, striving for improvements, building relationships and having a management team that is committed to developing a working environment based on trust, respect, cooperation and teamwork. Goals and objectives sit under key headings of consumer focus (aged care, chronic health conditions, young people with disabilities and mental</p>

to the needs of consumers.		<p>health) for provision of effective programmes, meeting certification and contractual requirements, quality and risk management and continuous improvement. Action plans are time-framed and include allocated responsibilities.</p> <p>There are three directors in the Hardwill Group and one of these meets the managers once a month. Records of these form reports that are shared with the other directors. A sample of the monthly records to the board of directors/owners showed adequate information to monitor performance is reported including financial performance, emerging risks and significant resident and/or staff issues. Full management meetings occur every three months and quality and risk management is a component of these.</p> <p>The service is managed by a manager who has served the organisation for over 15 years. Approximately two months ago a registered nurse manager was employed, and the two managers are now sharing the management responsibilities. Both managers are registered nurses with relevant management experience within the aged care sector. Responsibilities and accountabilities are defined in separate job descriptions and individual employment agreements. The manager and the registered nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and they maintain currency through ongoing attendance at in-service education and at New Zealand Aged Care Association meetings, involvement in a leadership forum and one has completed the e-learning modules for retirement villages.</p> <p>The service holds Aged Related Residential Care Agreements with the Bay of Plenty district health board (DHB) to provide rest home level care (currently nine residents) and hospital level care (currently four residents). Eight people receive care and support under long term support – chronic health conditions contracts with the DHB and seven people receive Ministry of Health funding under Young Persons with Lifelong Disabilities (YPD) contracts (three hospital and four rest home level). One person is funded via the Accident Compensation Corporation (ACC) and another person is on a special DHB package of care funding for mental health support.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The manager and the registered nurse manager are in the position to relieve one another when either is absent as they share the duties and responsibilities for management of The Lodge including sharing on-call roles. There is reportedly no likelihood of both managers being on any planned absence at the same time. Meeting and reporting arrangements with governance are able to be maintained.</p> <p>As both managers are registered nurses, one is also able to relieve the other for on-call clinical support for the team of registered nurses. Staff reported confidence in the current management and clinical teams and confirmed that the young people with disabilities are well supported, including from the director.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The 2020 Lodge Quality Plan includes a list of quality activities and goals with detailed steps of ways each will be achieved, who will be responsible and the timeframe for each step. Quality activities listed include health and safety, quality systems, food safety, diversional therapy, staff education, emergency management, care planning, infection control and market emphasis for The Lodge. The planned quality and risk system reflects the principles of continuous quality improvement and includes incident reporting, complaints management, health and safety management, internal audit activities, an annual resident satisfaction survey and monitoring of clinical incidents including infections and challenging behaviours.</p> <p>Three sets of both management meeting minutes and staff meeting minutes were reviewed and confirmed regular review and analysis of the listed quality indicators is occurring and that related information is reported and discussed. Staff reported their involvement in quality and risk management activities through actively contributing to these meetings. Relevant corrective actions are developed and implemented to address any identified shortfalls, especially from incidents, complaints and internal audit processes. Resident and family satisfaction surveys are completed annually. The most recent survey showed high levels of satisfaction overall with suggestions for improvement related to the time of evening meals, night checks and management of incidents. The young people with disabilities were especially open in their responses and each suggestion has been personally followed up by the managers in consultation with one of the directors. Regular residents' meetings chaired by one of the residents, who is a young person with a disability, are occurring and are minuted. Issues of concern are discussed between the young person and one of the managers.</p> <p>Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process and needs of young people with disabilities. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. A policy and procedure on document control lists the various manuals available and describes how the issue of new documents and removal of obsolete documents is managed. A document control flow chart describes the full process.</p> <p>The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. There is a risk management matrix which is monitored within the quality system, as is the hazard register. Contents of a comprehensive health and safety manual are implemented by the manager who is familiar with the Health and Safety at Work Act (2015).</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to staff and management meetings. An annual summary of the analysis of data related to adverse events 2019 – 2020</p>



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>was reviewed. This included graphs of types of incidents, time of day and contracts. Data from one person was not included in the incident/accident data as this was recorded separately in the resident's personal file.</p> <p>Both managers described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes an initial interview, referee checks, police vetting and validation of qualifications. A sample of staff records reviewed confirmed the organisation's policies are being implemented and records are maintained; however, a number of staff have been at the facility for some years and records were not always available in those staff files. Records of current annual practising certificates (APCs) for all health professionals attending residents including registered nurse, GP, a nurse practitioner and a podiatrist confirmed currency of their annual practising certificates. The dietitian's APC expired in March 2020; however, this person has since retired, and the menu is still current.</p> <p>Staff orientation is consistent with the induction and orientation policy and procedure. The process includes review of all necessary components and competencies relevant to the role. Staff reported during interviews that the orientation process and health and safety induction prepares new staff well for their role. They also noted that the timeframe during which they are buddied with an experienced staff member may be lengthened depending on previous experience. Staff records reviewed show documentation of completed orientation checklists and evidence of an interview with the manager after a three-month period.</p> <p>Continuing education is planned according to a two-yearly programme that includes mandatory training requirements. The training schedule has been altered to accommodate the challenges related to the Covid-19 pandemic requirements; however other creative approaches including YouTube and on-line courses are now being used to complement the monthly in-service sessions. Additional topics specifically cover the needs and interests of the young people with information on specific diagnoses including multiple sclerosis and Parkinson's disease as well as on meeting specific personal goals. Non-attendance at mandatory in-service training is followed up by the manager who requires the person(s) to complete one-on-one updates. The majority of care staff have completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A manager is an internal assessor for the programme. Three of the six registered nurses are maintaining their annual competency requirements to undertake interRAI assessments and a fourth is about to commence the training. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Although an acuity tool is not used, the managers described how staffing levels are adjusted to meet the changing needs of residents, such as in the event of an infection. Registered nurses liaise with managers when additional staff are required.</p> <p>An afterhours on-call roster is in place for the two managers who cover 24 hours at a time. Care staff confirmed there is always sufficient senior staff available for support and advice when needed and that there are adequate staff available to complete the work allocated to them. Residents interviewed are satisfied with the staff who assist them.</p> <p>Observations and review of a four-week roster cycle confirmed adequate staff cover is being provided, with staff replaced by a casual, or a part-time staff person in any unplanned absence. All registered nurses and the managers have a current first aid certificate; therefore there is always at least one staff member on duty who has a current first aid certificate. Rosters sighted confirmed there is 24//7 registered nurse coverage to ensure contractual requirements are met for the hospital level care residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>A resident register is maintained of all current and past residents. Residents' individual information is kept in paper and electronic format. The resident's name, date of birth and National Health Index (NHI) number are used as the unique identifier on all residents' information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with the GP and allied health service provider notes. Written records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>All assessments are completed by suitably qualified personnel prior to entry. The assessment documents are a pre-requisite before admission. Assessments confirming appropriate level of care and placement authorisation were completed. RN managers will go and assess the prospective client prior to admission to ascertain suitability to the service. The Lodge's welcome pack contains all the information about entry to the service and this is clearly communicated to the residents, family/whanau where appropriate, local communities and referral agencies. Family/whanau and residents interviewed confirmed that they received sufficient information regarding the services to be provided.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There is a documented process for the management of transfers and discharges. A standard transfer notification form from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families were involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.</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>There is a documented policy on the management of the medication system. All medication entries sampled confirmed that they were reviewed as required. Allergies were documented, identification photos were present and three-monthly reviews were completed. The RN was observed administering medication correctly.</p> <p>Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from hospital, for new admission or when there are any medication changes. The service uses pharmacy pre-packed packs that are checked by the RNs on delivery.</p> <p>The controlled drug register was current and correct. Weekly and six-monthly stock takes were conducted, and all medications were stored appropriately. Medication audits were conducted, and corrective actions have been acted on. Monitoring of medication fridge and room temperature was conducted.</p> <p>There were no residents self-administering medication and there is a policy and procedure for self-administration of medication if required. Self-administration of medicines is encouraged for YPD residents who wish to do so if appropriate.</p> <p>An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medicines management system complies with legislation, protocols, and guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Residents' food preferences were assessed on admission to identify dietary requirements, likes and dislikes and was communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. Meals were served warm in sizeable portions required by residents and any alternatives were offered as required. The residents' weights were monitored monthly and supplements were provided to residents with identified weight loss issues. Snacks and drinks were available for residents as and when required. The family members and residents interviewed acknowledged satisfaction with the food service.</p> <p>There was an approved food plan for the service. Meals are prepared on site and served in the allocated dining rooms. The menu was reviewed in March 2020 by a registered dietitian to confirm it was appropriate</p>

		<p>to the nutritional needs of the residents. There is a four-weekly rotating winter and summer menu in place. There is one resident who prepares their own meal daily in the kitchen and has been taught on food handling and is constantly supervised by the cook.</p> <p>All food services staff have completed training in food safety/hygiene. The kitchen and pantry were clean, tidy, and well stocked. Labels and dates were on all containers and records of food temperature monitoring, fridges and freezers temperatures were maintained. Regular cleaning was conducted.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The RN/M reported that all residents who are declined entry are noted. When a resident is declined entry, family/whanau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider.</p> <p>In the event of a person proving unsuitable for the service, the contract gives the service provider an option to serve an eviction notice. There was evidence in documentation viewed and during interviews with the managers that a person with challenging behaviours was causing disruption and presenting a risk to other residents. This person had been served an eviction notice more than one month previously as The Lodge was no longer considered to be an appropriate place for this resident. Efforts by the service provider to explore other options, including other service providers and social housing units, had not been successful and the service provider was reluctant to formally evict without ensuring the person had adequate ongoing support. Email evidence confirmed other relevant authorities were kept updated and a one on one support person was instituted on day one of the audit. The eviction notice had since expired. As the risk to other residents remained high and management of the person had become increasingly problematic, a high-risk corrective action was raised during the audit, and the Ministry of Health (HealthCERT) was advised accordingly.</p> <p>The situation was resolved due to action taken by the DHB whilst the audit team was on site. Around mid-day on day two of the audit, the person was transferred to another service provider. This process was respectful, the person involved was taken to visit the prospective provider and they were happy with the decision. These actions taken during the audit removed the associated risks to the remaining residents and the corrective action was considered to be closed.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered</p>	PA Low	<p>Residents had their level of care identified through needs assessment by the assessment agency from the local district health board. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.</p> <p>An improvement is required to ensure interRAI assessments are completed in a timely manner and are</p>

and recorded in a timely manner.		aligned to long term care plans and activities plans.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The assessment findings in consultation with the resident and/or family/whanau, inform the care plan and assist in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. Family/whanau and residents interviewed confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the resident such as the mental health services for older people, disability services, district nurses, physiotherapist, podiatrist, dietitian, NP and GP.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Interventions were adequate to address the identified needs in the care plans. Significant changes were reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. The GP reported that medical input was sought in a timely manner that medical orders are followed, and care is person centred. Care staff confirmed that care was provided as outlined in the care plan.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The Lodge has an activity programme in place that covers rest home, hospital and YPD residents. The diversional therapist (DT) reported that the service uses an online Golden Carers programme which informs each resident's activities programme and planning. Activity plans were reviewed at least six monthly or when there is any significant change in participation, and this is conducted in consultation with the nursing team, however these were not being evaluated at the same time with interRAI assessments (Refer 1.3.4.2). Over the course of the audit, residents were actively involved in a variety of activities. Activities were modified according to abilities and cognitive function. The activities vary from scrabble, bingo, music, movies, exercises/walking, and church services every weekend. External activities included life skills and health, personal development, self-help recovery focussed programmes especially for those with intellectual and physical disabilities. The DT reported that group activities and one on one activities with some residents were held.</p> <p>The planned activities and community connections are suitable for the residents. There were regular outings/drives, for all residents (as appropriate). Residents and family members interviewed reported that a variety of activities were provided including regular outings/drives.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses and care staff completed progress notes on every shift. All noted changes by the care staff were reported to the RNs in a timely manner.</p> <p>Formal care plan evaluations, following interRAI reassessments to measure the degree of a resident's response in relation to desired outcomes and goals, occur every six months or as a resident's needs change. Long-term care plans and activities plans were not reviewed along with interRAI assessments (refer 1.3.4.2). Evaluation/reviews were carried out by the RNs in conjunction with family, GP, NP, and specialist service providers. Where progress was different from expected, the service was seen to respond by initiating changes to the service delivery plan.</p> <p>Short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau were included and informed of all changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers where required. If the need for other non-urgent services are indicated or requested, the GP, NP and the nursing team sends a referral to seek specialist services assistance from the district health board (DHB). Referrals are followed up on a regular basis by the registered nurses, NP, or the GP. The resident and the family were kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals were attended to and the resident transferred to the public hospital in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Waste removal is undertaken by contractors and includes the removal of recyclables. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. The mitigation of risks associated with waste and hazardous substances is included in the hazard register.</p> <p>There is provision and availability of protective clothing and equipment and some staff were observed using this. The managers include the use of personal protective equipment during new staff orientation and in infection prevention and control updates and informed they proactively encourage staff to use it.</p>

<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness with an expiry date of 29 June 2021 was obtained during the audit and is now publicly displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment are current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment. Hot water temperatures in a random sample of residents' rooms and communal areas are checked monthly and are safe. Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted. Residents on the contract for young people with disabilities have their personal equipment of hoists and wheelchairs maintained as required with individualised adjustments maintained.</p> <p>External areas are extensive with a range of different settings varying from bush, to orchards and gazebos. All are being safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents and staff confirmed they knew who to talk to and the processes they should follow if any repairs or maintenance are required. A record of maintenance requests confirmed these are appropriately actioned. The residents enjoy their environment and do not want to leave.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of bathroom and toilet facilities throughout the facility. This includes six stand-alone toilet, one stand-alone shower and four combined toilets and showers. Two people have their own ensuite and there is one shared ensuite between two rooms. Hospital level care residents have access to toilets and bathrooms that are wheelchair accessible. Over half of the residents' rooms now have a hand basin and efforts to increase this number are ongoing. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Rooms are personalised with furnishings, photos and other personal items displayed. Bedrooms are of varying sizes and all bedrooms provide single accommodation. Most are allocated according to resident's</p>

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		<p>needs with larger rooms given to hospital level care residents. One of the younger residents has chosen to remain in a smaller room that they had prior to needing hospital level care and staff confirmed this is working out well. Another hospital level care younger person with a disability is in a large room of their choice, which has an ensuite; however, the hallway leading to the room is narrow and this level of care could not normally be satisfactorily provided in the room. In this instance the person is still mobile, and it is not a problem.</p> <p>Due to a request from the Ministry of Health for a partial provisional audit regarding a request to reconfigure the services by adding six more hospital beds. All bedrooms on one end of the ground floor where larger bathrooms are available were examined by using a wheelchair and checked for use of a hoist. Five more rooms, in addition to the previously approved six hospital beds and one medical bed, could be used for hospital level care residents on the proviso some of the furniture, such as larger chests of drawers are removed. There would still be sufficient storage area for residents' belongings. The owner/director was clear that these rooms are wanted to enable current residents to remain at The Lodge when their health deteriorates, especially as placement elsewhere could be a challenge. A sixth suitable room could not be found.</p> <p>There is room to store mobility aids and wheelchairs, as required, in residents' rooms. Staff reported that although extra room makes it easier to negotiate equipment around, they are managing to do this even in the smaller rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. There is a downstairs dining and sitting room, and a separate lounge and small activity room. A small to medium dining and sitting area with a pool table nearby is on a mezzanine style level accessible from the ground floor via a ramp. A large spacious lounge upstairs is only accessible by stairs. Many residents are mobile and are able to manage the changes in levels throughout the facility; otherwise there is sufficient room downstairs for people to move around, including with mobility aids. Residents can go to their room for privacy, if required, or they may use one of several small sitting areas around the facility. Furniture is appropriate to the setting and residents' needs. There are areas around the building where any resident may go for privacy, including the young people with disabilities, although some said they just like to go to their room, or outside such as in the courtyard.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in</p>	FA	<p>Laundry is undertaken on site in a dedicated laundry by care staff on various shifts, some of whom have allocated laundry hours to ensure the laundry is done in a timely manner. The staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed informed they had no concerns about the laundering of their clothes.</p> <p>A person from the company that supplies the household cleaners goes on site to The Lodge every month in addition to providing staff with six monthly training sessions on chemical use and safety. This was confirmed</p>



which the service is being provided.		<p>during a staff interview and was evident in staff and training records. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers. Material safety data sheets were near the relevant products and a hazard monitoring checklist for the laundry was dated October 2020. The housekeeper described processes, including the use of different colour clothes for different purposes.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. These include meeting the needs of all residents on any contract. The current fire evacuation plan was approved by the New Zealand Fire Service on the 27 November 2017. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 20 September 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, and gas BBQ's were sighted. On initial inspection it was found that some expiry dates on food in the lower shelves of the emergency food stocks went as far back as 2004. The items were changed over immediately with items from the kitchen pantry and the pantry subsequently restocked during the audit. The stocks available meet the Ministry of Civil Defence and Emergency Management recommendations for the region. Water storage tanks are located around the complex, and they have access to an on-site spring. Emergency lighting is regularly tested, and additional blankets are available if required.</p> <p>There are call bells to alert staff about residents requiring assistance. Call system audits are completed on a regular basis and residents reported staff respond promptly to call bells. This was confirmed in observations made during the audit, with senior staff also being responsive to call bells.</p> <p>The director and manager informed there had never been any security breaches. Appropriate security arrangements are in place with doors and windows locked at a predetermined time at night. At the afternoon to night shift changeover, staff do a joint security check and sign this off.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is</p>	FA	<p>All residents' rooms and communal areas have external windows that can be opened for ventilation. There is good natural light in residents' rooms and most of their rooms, including those upstairs, have a door that opens onto a patio, or a balcony. A fan in the dining room is used to improve humid conditions in summer months.</p> <p>Individually adjustable electric heating units and panel heaters are wall mounted in residents' rooms, the hallways and the communal areas. Residents reported the facilities are maintained at a comfortable</p>

maintained at a safe and comfortable temperature.		temperature and that if they are cold, they can either turn the heat up, or ask for this to be done for them. There was no evidence of any areas being cold and damp, and nor were there any reports of such issues, even when residents were specifically asked.
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The Lodge has implemented an infection prevention and control programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a current infection control manual, with input from external specialists. The infection control programme is reviewed annually and was incorporated in the monthly meetings and a review of the education programme is conducted.</p> <p>The RN managers share the role of the designated infection prevention and control coordinator (ICC). Role and responsibilities were defined in their job descriptions. Infection control matters, including surveillance results were reported three-monthly to the director and to the three-monthly staff and management meetings. Residents were updated monthly during their residents' meetings.</p> <p>The infection control manual provides guidance for staff on how long they must be away from work if they have been unwell. Staff interviewed understood these responsibilities. Vaccination is encouraged for staff and residents.</p> <p>There is information that covers aspects of infection control for family/whanau and if they are unwell; it is recommended that they do not visit the service. During higher risk times of community infections and winter months, notices are placed at the door to remind people not to visit if they are unwell. There is sanitising hand gel at the entrance and throughout the service. Hand washing facilities and sanitiser dispensers are readily available around the facility.</p> <p>No infection outbreak has been reported since the previous audit. Pandemic and infectious disease outbreak plan was in place. Information on the management of the Covid-19 was readily available for residents, staff, and visitors.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the</p>	FA	<p>The infection prevention and control coordinators (ICCs) have appropriate skills, knowledge and qualifications for the role and has attended specific education related to infection prevention and control.</p> <p>Additional support and information are accessed from the infection control team at the DHB and the NP and GP as required. The coordinators have access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The coordinators confirmed the availability of resources and external specialists to support the programme and any potential outbreak of an infection.</p>

organisation.		
<p>Standard 3.3: Policies and procedures</p> <p>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.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. The policies and procedures are developed by the organisation with advice from external specialists. Policies were last reviewed on 2 January 2020 and included appropriate referencing.</p> <p>Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Staff education on infection prevention and control is conducted by the ICCs and other specialist external consultants. The education information pack is detailed and meets best practice and guidelines. The infection control coordinator attended infection prevention and control training conducted by an external consultant to keep their knowledge current. A record of attendance was maintained and was sighted. External contact resources included the NP and GP, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.</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>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they were informed of infection rates at three monthly staff meetings and through compiled reports. The GP or NP are informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively.</p>
Standard 2.1.1: Restraint	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordination role has been</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>the manager until the recent appointment of the registered nurse manager. It has now become a joint responsibility. Both managers demonstrated a sound understanding of the organisation's policies, procedures and practice and their role(s) and responsibilities.</p> <p>On the day of audit, none of the residents were using a restraint and one person was using an enabler. The enabler in use is a lap belt, which is attached to the person's wheelchair. Appropriate documentation is in this person's file, which confirms its use is voluntary. Staff reported the person seldom uses the lap belt.</p> <p>Both managers reported that restraint would only be used as a last resort when all alternatives had been explored. The manager informed the last use of a restraint was approximately 15 years ago. There were two records in the restraint register: one being an enabler that has been discontinued and the other noting the lap belt currently in use by one resident.</p>
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## 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 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Low	Initial nursing assessments were completed on admission while residents' care plans and interRAI assessments were completed within three weeks according to policy. Assessments and care plans were detailed and included input from the family/whanau, residents, and other health team members as appropriate. Additional assessments were completed when needed; this included pain, behavioural, falls risk, nutritional requirements, continence, skin, and pressure injury assessments. The nursing staff utilised standardised risk assessment tools on admission	(i) Review of interRAI assessments were not occurring at the same with long term care plans and activities care plan evaluations. (ii) Four interRAI assessments were overdue.	<p>(i) Provide evidence that interRAI assessments are completed and evaluated along with long-term care plans and activities plans.</p> <p>(ii) Ensure that all interRAI assessments are completed in a timely</p>

				manner.
				180 days

# 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.