

Jass Holding Limited - Janelle Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Jass Holding Limited

Premises audited: Janelle Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 27 May 2021 End date: 28 May 2021

Proposed changes to current services (if any): Total beds occupied across all premises included in the audit on the first day of the audit: 13

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.

General overview of the audit

Janelle Rest Home provides rest-home level care for up to 21 residents. Occupancy was 13 on the days of the audit. A change in ownership is anticipated to occur in late June 2021. The service is managed by the owner/director, facility manager (FM) who is assisted by a newly appointed clinical manager (CM) responsible for day-to-day clinical management of the service. Feedback from family members and residents was positive about the care and services provided.

This provisional audit was conducted against the relevant Health and Disability Standard and the contract with the District Health Board. The audit process included an interview with the prospective owner, review of policies and procedures, review of resident and staff files, observations, and interviews with family, general practitioner (GP), management, and staff.

The audit has resulted in two identified areas requiring improvement relating to medication management, and testing and tagging residents appliances.

Consumer rights

Residents' rights are understood and met in everyday practice. Communication channels are defined, and interviews and observation confirmed communication is effective. Sufficient information on rights and advocacy services is provided.

Residents are free from discrimination, exploitation and abuse, and neglect. The residents' cultural and spiritual needs are respected, and cultural safety policies demonstrate a commitment to the principles of the Treaty of Waitangi. Residents are encouraged to have a choice in daily activities.

Family members confirm an understanding of their right to make a complaint or raise a concern. Any complaints or concerns are followed up by the facility manager with evidence of action taken to address issues.

Organisational management

The business plan and quality indicators serve to provide direction and to document the organisation's mission and vision statements. A transition plan outlines the focus for the potential owner. The goals, indicators, policies, and procedures are documented and reviewed. Day-to-day operations are the responsibility of the owner/director (FM) and CM, respectively. The prospective owner has the required knowledge and skills to manage a rest home and will be supported by the clinical manager and the other owner/director who is a solicitor/barrister.

Quality and risk management systems are defined, monitored, and maintained. This includes adverse events, health and safety, and infections. Internal audits include corrective action plans and evidence of resolution. The sale and purchase of the service will include the entire documented quality and risk management system.

Human resource processes ensure that a sufficient number of staff are always available. There is a defined process for orientation and training. Competencies are monitored. Resident information is held securely and meets all requirements for health records management.

Continuum of service delivery

The owner/director (FM) and CM assess and develop care plans in consultation with the residents and their families. The residents' needs and care requirements are evaluated as required. The required personal care and clinical interventions are implemented. Resident centred care plans are reviewed every six months and short-term care plans are consistently developed when acute conditions are identified.

Planned activities are appropriate for the residents' assessed needs and abilities. Residents and family interviewed expressed satisfaction with the activities provided by the activity's coordinator with oversight from the CM.

A safe medication management system is in place and meets legislative guidelines and policy requirements. Medication is managed via an electronic platform. Medication is administered by staff with current medication competencies. All medication charts are reviewed by the general practitioner (GP) as required.

Meals are cooked on-site and the menu meets cultural requirements and requests. The meal service meets the individual food, fluids, and nutritional needs of the residents. Residents with special dietary needs are catered for. The food control plan certificate is valid and menu review is completed every two years.

Safe and appropriate environment

The facility has communal lounge and dining areas with an outdoor area. The building, facilities, furnishings, and equipment are maintained and suitable for people identified as needing rest home level of care. Applicable building regulations and requirements are met. The building holds a current warrant of fitness which expires on 08 November 2021. The facility has plenty of natural light and is maintained at a comfortable temperature.

Cleaning and laundry services meet infection control requirements and staff comply with safe waste and hazardous substances processes. The organisation has appropriate stores and equipment in the event of a civil defence emergency.

The prospective owner does not intend to make changes to the facility in the immediate future.

Restraint minimisation and safe practice

Janelle Rest Home has implemented policies and procedures that support the minimisation of restraint. There were three enablers in use and no restraints at the time of audit. Restraint is only used as a last resort when all other options have been explored. Staff demonstrated sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

The infection prevention and control management system are in place to minimise the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating the education and training of staff. The required policies and procedures are documented. Infection data is collated monthly, analysed, and reported during staff meetings. Covid-19 precautions and guidelines are in place. 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	48	0	1	1	0	0
Criteria	0	99	0	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>All staff interviewed demonstrated knowledge and understanding of resident rights, obligations, and how to incorporate them as part of their everyday practice. Staff address residents with respect, knocking on doors, asking to enter rooms before entering, and providing residents with choices. Staff interviewed understand consumer rights and are aware of consumer rights legislation. Training in the Code of Health and Disability Services Consumers` Rights (the Code) has been provided.</p> <p>The prospective provider is a qualified registered nurse and is aware of the requirements under the Code. A comprehensive list of the activities the prospective provider intends to maintain is documented in the business risk management plan and transition plan. This includes activities relating to the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	FA	<p>Staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files sampled verified that informed consent had been gained</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>appropriately using the organisation's standard consent form. These are signed by competent residents or the enduring power of attorney (EPOA). The general practitioner makes a clinically based decision on resuscitation authorisation of residents deemed not competent. Sampled files evidenced signed resuscitation decisions and advanced directives by residents who are deemed competent. The owner/director (FM) reported that residents were informed about advance directives from admission and on an ongoing basis but most of them were not willing to complete the process. Therefore there were no residents with advance directives.</p> <p>Staff was 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>
<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>	<p>FA</p>	<p>Policies and procedures required that residents be informed of their right to access independent advocates. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members and residents were interviewed to confirm that they understand these rights and their entitlement to have the support person of their choice available if they choose.</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>	<p>FA</p>	<p>There is a policy on family participation. Residents have ongoing close contact with family members, who are encouraged to visit as often as they want. A number did this while the audit was on. Some spoke about how the staff assisted with ongoing phone contact when Covid-19 lockdown prevented actual visits. Residents access a range of community services and activities. The service hires a van to assist with transport and additionally, taxis are used.</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>	<p>FA</p>	<p>The service has a complaints management policy and procedures in place that align with the Code. The services complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All complaints sighted in the register had been resolved. Complaints'</p>

		<p>information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. The complaints register had the following complaints recorded; 2019 (eight), 2020 (two), and 2021 (three) including one which was reported to the local district health board. All these were fully investigated and closed out. Residents and family were advised of the complaints process on entry to the service. This included written information about making complaints. Residents interviewed described a process of making complaints that includes being able to raise these at the regular residents' meetings, putting a complaint (which can be anonymous) in the suggestion box, or directly approaching staff or the management.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	FA	<p>Policies are in place to guide staff actions and ensure residents' rights are discussed. Family communication forms were completed, and these confirmed that the family was informed of rights and engaged in discussions.</p> <p>The Code was displayed throughout the facility. Information about the Code is provided in the admission pack and included in the resident agreement. The Nationwide Health and Disability Advocacy Service poster and pamphlets were also displayed.</p>
<p>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.</p>	FA	<p>The residents' privacy and dignity were respected. This was confirmed in an interview with family/whanau and residents who expressed a high level of satisfaction with the service. Those interviewed expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</p> <p>There is an abuse and neglect policy available to staff and staff interviewed understood how to report such incidences if suspected or observed. The owner/director (FM) reported that any allegations of neglect, because of service delivery, were taken seriously and immediately followed up. There were no incidents of abuse or neglect documented in the incident forms or the complaints register. The GP stated that there was no evidence of any abuse or neglect.</p>

		<p>Residents were able to move freely in and out of the facility and into the surrounding areas with no restrictions. Exit doors are alarmed for residents' safety.</p> <p>The residents' preferred name was ascertained on admission, documented, and used by staff when addressing residents or family members. Individual values and wishes were considered. This was evident in resident records sampled. Spiritual needs were considered and catered for with church services provided monthly.</p> <p>Family/whanau interviewed described that staff were respectful and provides an environment that is family orientated.</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. Assessments and care plans document any cultural/spiritual needs. There was one resident who identified as Maori and had a Maori health care plan in place. In the interview conducted, family/whanau and resident confirmed that all their cultural needs were met. Special consideration to cultural needs is provided in the event of death. The required activities and blessings were conducted. All staff receives cultural training every two years.</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 recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Family members were interviewed to confirm that the resident's values and beliefs are actively recognised and well supported. This was confirmed by residents and through observations of interactions between staff and residents during the audit. Values and beliefs were discussed and incorporated into the care plan. The family interviewed gave examples of being actively involved in any changes in routine for their family member.</p> <p>Staff interviewed were able to describe how each resident can make choices around activities of daily living and activities. Residents on the day of the audit were observed to actively engage in activities of their choice.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Janelle rest home has a policy on discrimination in place. This includes guidelines for staff regarding the prevention, identification, and management of discrimination, harassment, and exploitation. The owner/director (FM) reported that the rights of the individuals were protected, and interventions occur to ensure a balance between the personal rights of the individual and others living and working in the facility. All family interviewed reported that they believed their family members were always safe.</p> <p>Staff received training on professional boundaries and code of conduct. The Code of Conduct which includes House Rules is signed by each staff member on entry to the service. Situations that constitute misconduct are included in staff employment agreements. The owner/director (FM) 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>	<p>FA</p>	<p>There are policies and procedures to guide practice. There is a training programme implemented and staff interviewed described best practices based on policies and procedures. All family interviewed stated that each resident receives 'good care and support' with staff conscious of managing all residents' identified needs effectively.</p> <p>Consultation with key health professionals and services occurs as required for individual residents as sighted in resident records. The GP confirmed that they visit the facility at least weekly with each resident having a medical review at least monthly. The GP reiterated that there is good communication between medical staff and the staff in the facility and any instructions were carried out on time. The staff is also noted to inform the general practitioner of any issues as they arise.</p> <p>Health care assistants (HCA) and the clinical manager were able to describe the practice as per policy. HCAs had completed level three and four CareerForce qualifications, some reported that they were considering enrolling. The current owner/director (FM) and the CM completed the required annual education competencies. Training such as the Nursing Council of New Zealand (Code of Conduct),</p>

		<p>infection prevention and control principles, basic life support skills assessment primary responder, restraint minimisation and safe practice assessment, privacy act, annual interRAI competencies including other in-house training were completed.</p> <p>The potential owner confirmed during the interview that they are intending to keep the existing systems in place around clinical 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>There is evidence that the service adheres to the practice of open disclosure. The owner/director (FM) reported that all adverse events were managed in an open manner, and these were put in the context of quality improvement. This was evident in adverse event reports and interviews with family members and residents.</p> <p>Access to interpreter services is available through the district health board if required. At the time of the audit, there were no residents who required an interpreter. Staff was observed to engage with residents in a way that involves them as much as possible. Staff can provide interpretation as and when needed and the use of family members and communication cards when required is encouraged.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The service is up for sale and the prospective owners have commissioned a provisional audit. Janelle Rest Home is potentially to be purchased by the new prospective owners (Jass Holding Limited). The prospective owners have an established organisational structure outlined in their business/transitional plan. The future arrangements will be prospective owners will have roles of being directors and be in the management supported by the current staff at Janelle. A current business plan was sighted which is based on delivered service, objectives, and performance measures. The purpose, values, scope, direction, and goals of the organisation were clearly outlined.</p> <p>The transition plan/business plan sighted includes how the prospective owners will be transitioned into the running and management of the service under the support of the current management. The business plan includes time frames for maintaining</p>

		<p>the current quality system, policies, and procedures, staffing, and service delivery. The prospective owner intends to retain the current service as is. Future changes will be considered on a need basis and covered in the business plan. The planned settlement date is 28 June 2021. The prospective owners and the current owner/director (FM) reported that the planned transition time will be for 10 days or more if required. All files sampled evidenced that residents were receiving the appropriate level of care.</p> <p>The prospective owners have vast experience in the health and legal sector in New Zealand. The other owner/director is a registered nurse with over 20 years of clinical experience and has worked as a care home manager in the NZ aged care sector for the past 12 years. The other director has a legal background admitted as a barrister and solicitor of the High Court of New Zealand in 2016. In an interview conducted the prospective owner/director reported that they will be responsible for the management of the facility. There will be no change to the clinical management.</p> <p>The service is operated by CRK Holding. The day-to-day management of the services at present is conducted by a full-time owner/director (FM). All members of the management team are suitably qualified and maintain professional qualifications in management, finance, and clinical skills. The owner/director (FM) had completed eight hours annually of professional development activities related to management. The clinical manager who deputises for the owner/director (FM) when absent, has been working at the facility since April 2021. Responsibilities and accountabilities are defined in the job description and individual employment agreement.</p> <p>The facility has an Aged Related Residential Care Contract (ARRC) with ADHB for the provision of rest home, respite care (contract with the DHB), and rehabilitation services (through contracts with ACC). At the time of the audit, the 13 residents included one resident referred through ACC, 12 rest home residents, and (Nil) respite resident.</p> <p>The potential owner had visited the service and is being supported by the current owner to transition into the service.</p>
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<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>	<p>FA</p>	<p>Day.-to-day activities are the responsibility of the owner/director (FM) with the support of a clinical manager. The potential owner plans for the clinical manager to continue to provide clinical oversight and day-to-day operational management of the service when absent.</p> <p>Following the purchase, the management role will be taken over by the potential owner. The new management role will involve accounting, administration, staffing, and overall management of the service. The transition plan states that the owner intends to be onsite during the week with considerable input initially. The potential owner will be onsite for at least 40 hours a week. The clinical manager will continue to provide 40 hours a week on-site with more hours allocated as tasks require particularly in the initial phase of ownership. The clinical manager will continue to work as the second in charge as required.</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 organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction surveys, monitoring of outcomes, clinical incidents, and accidents including infection surveillance.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities. All scheduled internal audits were completed, and relevant corrective actions were developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed yearly and evidence of this was sighted.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool process. Policies are based on best practices and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution, and removal of obsolete</p>

		<p>documents. These are managed by an external consultant who keeps the service updated on any recent changes. Interview conducted, staff confirmed that they have access to policies and procedures if required.</p> <p>The owner/director (FM) described the process for the identification, monitoring, review, and reporting of risks and the development of mitigation strategies. The owner/director (FM) is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. Chemical safety data sheets are available. Calibration of medical equipment is conducted and recorded.</p> <p>The prospective owners intend to continue with the quality and risk management programme.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near-miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up promptly. Neurological observations were completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed, and reported to the management, respectively. There is an open disclosure policy in place. Any communication with a family and general practitioner (GP) following adverse events and if there is any change in the resident's condition is recorded in residents' records. Family/whanau, residents and the GP interviewed confirmed they are notified in a timely manner.</p> <p>The owner/director (FM) described essential notification reporting requirements, including pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks, and missing persons. They advised that the only notification that was made to the MOH was for the clinical manager who was employed in April 2021.</p> <p>The prospective owners understand their statutory and/or regulatory obligations about essential notification reporting and notify correct authority where required.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures about human resource management complied with current good employment practices. Staff files sampled show appropriate employment practices and documentation. Current annual practicing certificates are kept on file. Police checks are undertaken. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The owner/director and clinical manager are interRAI trained and competency assessments were sighted in files sampled.</p> <p>The orientation/induction package provides information and skills around working with residents with rest home of level care needs. All new staff including the CM had been properly oriented into their roles and documents signed off. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal.</p> <p>Staff interviewed reported that the support and training they received provides them with the skills they need. Health care assistants confirm they are well supported by the owner/director (FM) and clinical manager. Residents and family interviewed stated that staff is knowledgeable and skilled.</p> <p>The prospective provider intended to make no changes to human resources processes.</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>	<p>FA</p>	<p>The service has a total of 13 staff including the owner/director (FM) currently working 12-hour shifts, six days a week. The clinical manager works (40-hours a week), and health care assistants' hours vary. A review of the past six weeks' rosters showed that all shifts were adequately covered. The documented rationale for determining service provider levels and skill mix is based on occupancy ratios. The owner/director (FM) oversees the roster with the clinical manager, ensuring that staff is on duty as allocated.</p>

		<p>The roster was randomly sampled and there are sufficient numbers of staff to cover the 24 hours. The owner/director and clinical manager are on call 24 hours a day, seven days per week with the potential owner able to be on call if the business is sold. Residents and families interviewed reported that there was enough staff to provide them or their relatives with adequate care. Observations during the audit confirmed adequate staff cover is provided.</p> <p>The prospective owner anticipates that staffing will remain at the current level and changes will occur as needed in the future.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>A resident register of all current and past residents is maintained. The resident's name, date of birth, and National Health Index (NHI) number are used as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical, and health information was fully completed in the residents' files sampled for review. Records of inquiries that are declined are maintained in a paper record. There was evidence that unsuccessful enquiries are referred to their referrer for alternative providers that may suit their needs. Clinical notes were current and integrated with GP and allied health service provider notes.</p> <p>Archived paper records are held securely on-site and are readily retrievable using a cataloguing system. The electronic records are backed up in the Cloud. All records sampled were legible, included the time and date, and the designation of the writer. 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 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 sample resident files reviewed had needs assessments before admission to the service, the required level of care has been confirmed by the local Needs Assessment and Service Coordination Agency (NASC). Admission information packs are provided for families and residents before admission or on entry to the service. Screening processes are communicated to the family/whanau of choice where appropriate, local communities, and referral agencies.</p>

		The signature of the enduring power of attorney (EPOA)/Family representative of each resident was in place in files sampled. Families and residents reported that the admission agreements were discussed with them in detail compassionately and respectfully. Files reviewed contained completed demographic details, assessments, and signed admission agreements following contractual requirements.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge, or transfer is managed in a planned and coordinated manner, with an escort /family member as appropriate. There is a documented process in place and open communication between all services, the resident, and the family. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. The service uses the DHB's yellow envelope system to facilitate the transfer of residents to and from acute care services. All referrals are recorded in the progress notes.
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 Moderate	The medication policies and procedures are aligned with legislation, guidelines, and best practice and are available to staff. The service uses an electronic medication prescribing and administration platform. All medication records contained a photograph of the resident and allergy status. PRN medications had indications and maximum doses and short courses medications had a start and finish date. PRN medication administration reason and outcome have been documented by the CM and competent health care assistants. An annual medication competency is completed for all staff administering medications and medication training records were sighted. All medication records had been reviewed within the past three months by the general practitioner. Medications are dispensed and delivered from a local contracted pharmacy. All medications are checked, and medication reconciliation is conducted by the CM. Health care assistants administer medication under the direction and delegation of the CM. A medication round was observed, the principles of safe medication administration were followed. No residents were self-administering medication during the audit. A

		<p>self-administration procedure is available, covers the self-administration competency test. Storage and consent taken, GP review and approval. Self-administration of medication is generally used at the facility as required for topical medications only. Medication training to health care assistants is provided annually via the CM. The CM completed medication training within the past 12 months. Safe management of missed medication and reporting of medication process is followed if required, no reports received of missed medications or medication error as confirmed by the CM.</p> <p>Weekly and six-monthly controlled drug stock takes are conducted, Pharmacist signature in CD register sighted. Monitoring of medication fridge temperatures is conducted, and records were sighted. No storage of vaccine at the facility. Health care assistants interviewed were aware of their scope of practice and stated they contacted the registered nurse before administration of PRN drugs, this was confirmed by the CM.</p> <p>Previous issues of concerns in medication management and reconciliation have been addressed by the CM and resolved.</p> <p>An improvement is required to ensure PRN medication held in stock has documented expiry dates.</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>	<p>FA</p>	<p>The current food service is satisfactory to accommodate the needs of the residents. Meal services are prepared on-site and served in dining rooms. The residents' weights are monitored monthly, and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents when required. There is a four-weekly seasonal rotating menu in use. The registered dietitian reviewed the menu within the last two years.</p> <p>Diets are modified as required and the cooks confirmed awareness of the dietary needs of the residents. Alternative meal options are offered as required. A nutritional profile is developed on admission and reviewed every six months or when there is any significant change. Diets are modified as required and the cook confirmed awareness of the dietary needs of the residents. Meals are served warm in sizeable portions required by residents and any alternatives</p>

		<p>are offered as required. Snacks and drinks are available for residents when required. The cook on duty reported feedback is taken from residents during meetings with residents and on a one-to-one basis. Evidence of resident satisfaction with meals was verified by resident and family interviews, a resident has access to online food purchase, she selects her food items, then chef cooks the items ordered as her taste and preference, this was shared by the resident during the interview. The service meets the individual food, fluids, and nutritional needs of the residents.</p> <p>The kitchen was registered under the food control plan. certificate of Kitchen audit by relevant authority valid. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges, and freezers temperatures are maintained. Regular cleaning is 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>	<p>FA</p>	<p>The CM 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>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Residents admitted to the service have an initial assessment completed within 24 hours. The initial assessment is comprehensive and utilises a range of assessment tools including but not limited to falls, skin, pressure area, behavioural, dietary, oral, pain assessment .and activities assessment. Files sampled evidenced ongoing assessment at six-monthly periods and more frequently if required. A wound assessment tool was in use. Family members interviewed advised that they had been notified when an updated assessment had been completed. All files sampled had a monthly recording of the resident's vital signs and weight. Residents with diabetes had regular</p>

		blood sugar levels documented.
<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>Care plans are developed using the interRAI assessment process, addressing the activities of daily living and the triggered outcomes by the interRAI. The care plans are easily accessible in the clinical record and written in language to ensure that the support and intervention required to meet the desired outcome are understood by all members of the health care team. Short-term care plans sampled contained a problem list, goal, intervention, evaluation, and completion date, and were appropriate for the identified problem and objective/goals. Files sampled integrated general practitioner assessment and documentation and there was evidence that the intervention/s were incorporated into updated care plans, both long term, and short term. The care plans sighted were specific, Maori health care plan prepared for Maori residents sighted. The plans resident-focused and contained evidence that the resident and family had been consulted and included in the development of the planning process, this was confirmed during resident and family interviews.</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>Short term and long-term care plans sampled included interventions appropriate to meet the residents' needs and desired outcomes. The care and interventions are regularly evaluated to ensure set goals are achieved. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP in the interview conducted. Wound assessment and wound care plans completed and sighted in sample files. The GP confirmed that the staff implements the prescribed interventions as required. Monthly observations are completed and are up to date including weight, blood pressure monitoring, and blood glucose monitoring. Behavior management plans were developed to describe types of behavior, possible triggers, and interventions. A range of equipment and resources were available, suited to the level of care provided and following the residents' needs. Staff confirmed they have access to the supplies and products they needed.</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>	<p>FA</p>	<p>The activities coordinator is newly appointed and assists with the implementation of the programme, and two caregivers carry the activities during the weekend. The CM develops and monitors the activities programme and conducts activities assessment on admission and regularly. Planned activities reflect the cultural and spiritual beliefs of the residents, choices, and preferences, and includes, but are not limited to outings, Bingo, painting, singing, walking groups, gardening, Church visits, and exercise programme. The activities coordinator has shown a good understanding of the activities provided, the residents were observed participating in a variety of activities on the audit days. Activities schedule is provided to residents and displayed in the facility. Clinical files sampled contained activities assessment, an individualised activity plan that complemented the long-term care plan. A review of the activities plan occurred as part of the six-monthly interRai assessment and care plan review. Residents and family members interviewed confirmed they are consulted on the development of individual activity plans and reported overall satisfaction with the level and variety of activities provided. Maori residents participate in the planned activities as per their choice and preferences, include Maori music, watching Maori TV channel and family/Whanau social activities, as confirmed by the RM and the Maori resident, a family representative could not be reached.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>InterRAI, care plans sampled were reviewed at six-monthly intervals or more frequently when indicated, with evidence that changes were made following evaluation. Short-term care plans were evaluated regularly, with the care plan being signed off when the problem was resolved or integrated into the long-term care plan if required. Monthly measurement check completed. Day-to-day monitoring and evaluation, when required, were reported in the clinical progress notes for each duty. When a resident's health status changes the CM is notified in the first instance and makes an assessment. If required, the general practitioner or other health care provider as appropriate may be notified and requested to attend the resident. The CM covers on-call 24hour with the support of the owner/director (FM). Family</p>

		members interviewed confirmed they were notified of any changes in the president's health status. The CM reported Residents started being reviewed regularly by the newly appointed GP, the GP started visiting the facility twice per month .and as needed. 24-hour on-call coverage is in place as confirmed by the GP during the interview. The GP confirmed multidisciplinary meetings (MDT) is planned to be held every three months on regular basis.
<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	There is a documented process for the management of all referrals. The service utilizes a standard referral form when referring residents to other service providers. The GP confirmed the referral process in place, referral records completed to ensure that all referrals are followed up accordingly. Resident and family/whanau are kept informed of the referrals made by the service. All referrals are facilitated by the CM or GP. Evidence is sighted in resident sample files and relevant records.
<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 follows documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The other owner/director is the designated maintenance person and ensures adequate stock is held onsite. The staff has completed the required chemical handling training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant staff training. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment, and the staff was observed using them.</p>
Standard 1.4.2: Facility Specifications	PA Low	A current building warrant of fitness is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>and facilities are fit for their purpose and maintained. Hot water checks are conducted monthly, with all readings below the maximum temperature.</p> <p>The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. There are ramps to enable disability access. Residents can walk around freely throughout the facility and grounds. External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned, and that they are happy with the environment.</p> <p>The prospective owner/director reported that there were no immediate planned changes to the environment.</p> <p>An improvement is required to ensure residents' electrical equipment such as refrigerators and microwaves are tested and tagged.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</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>	<p>FA</p>	<p>There are two main wings at the facility. One wing has shared facilities that comprise six rooms with shared bathrooms and toilets between each resident's room. In addition, there are four separate showers units close to the residents' rooms. The other wing of the facility has 11 rooms with a toilet and a washing basin. There are two rooms which are ensembles with a shower, vanity, and toilet facilities. There is one double room which is near bathroom/toilet facilities. The care staff interviewed confirmed there are enough bathroom and shower facilities for the residents' use. Privacy locks are present on the bathroom and shower doors that are accessible/utilised by residents.</p> <p>At the time of the audit, all toilet/shower/bathing facilities were observed to be clean and fit for purpose. Records of hot water temperatures were maintained to ensure that the water remained at a safe and consistent temperature. Visitor toilets are available throughout the facility.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. Personal privacy is maintained, and rooms are personalised with furnishings, photos, and other personal items displayed. There are 17 single bedrooms, one double room, and two ensuites. Residents were sighted mobilising inside the rest home independently including while using a mobility aid. The staff interviewed advised there is sufficient space for the residents to mobilise including when assistance was required. The residents and family members interviewed confirmed this.</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>	<p>FA</p>	<p>There are two lounges and two dining room areas. The communal areas are available for residents to engage in activities. The new outdoor chairs were purchased for the front entrance seating area. The owner/manager (FM) reported that an umbrella for the front seating area is available for use in sunny weather. There were no health and safety issues noted. The other outside seating area next to the new wing had well-maintained furniture with an outdoor umbrella to provide cover from the sun. The lounge door leading to the outdoor deck area enables easy access for residents and staff. Residents can access areas for privacy if required. Furniture is appropriate to the setting and residents' needs. An area of damaged carpet in the new wing lounge was covered with a new non-slippery protective mat. All curtains and curtain rails fittings were regularly cleaned and still fit for purpose.</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 which the service is being provided.</p>	<p>FA</p>	<p>Laundry such as bedding, and towels are washed off-site by a contracted provider and personal laundry is washed on-site or by family members if requested. Family/whanau and residents interviewed expressed satisfaction with the laundry management and those clothes are returned on time. Care staff received appropriate training in cleaning and chemical use. Chemicals were stored in a lockable cupboard and were appropriately labelled containers. Cleaning and laundry processes are monitored through regular feedback from staff, residents, family/whanau, internal audit programme, and corrective actions are acted upon. Slippery floors</p>

		<p>were kept dry and warning signs displayed when wet.</p> <p>Care staff demonstrated a sound knowledge of the laundry processes. Clear separation of clean and dirty areas in the laundry was sighted. The cleaning trolley was stored in a locked utility room when not in use.</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 defense planning guides direct the facility in the preparation for disasters. These describe procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service and this was completed, and evidence sighted. The orientation programme includes fire and evacuation. All staff had current first aid certificates. 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, mobile phones and gas cooking equipment, and BBQ were sighted and meet the requirements for the 13 residents at the service. Emergency lighting is regularly tested. Call bells and video screen monitor alert staff to residents requiring assistance. The call system is in place, residents and families reported staff respond promptly to call bells. Security cameras are in use to monitor the entrance and the communal areas. The images display on a screen in the manager`s office and the small lounge and are electronically archived for a period. The screen has password access only. The caregivers interviewed advise the external door and windows are checked and locked in the evening. All external windows and doors are also checked and secured at this time.</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 maintained at a safe and</p>	FA	<p>All residents` rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and some have doors that open onto the outside garden or small patio areas. Heating is provided by heat pumps with heaters available</p>

comfortable temperature.		for supplementary heating if required in residents' rooms and the communal areas. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.
<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 CM /Infection Control Coordinator (ICC) is responsible for the infection control programme. There are adequate policies and procedures for the size and scope of the service. Infection prevention and control is a standard agenda item in all monthly staff meetings. Recent infections, potential causes, treatments, and outcomes are discussed. There is a sign at the facility entrance requesting visitors who are unwell to avoid visiting, and relatives are informed of this when a resident is admitted. There are family meetings that cover aspects of infection control and if they are unwell, it is recommended that they do not visit the service. During Covid 19, higher risk times of community infections and winter season 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. Vaccination is offered for staff and residents.</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 organisation.</p>	FA	<p>The ICC has appropriate skills, knowledge, and qualifications for the role, is responsible for implementing the infection control programme (ICP), and reported there are adequate human, physical, information resources to implement the programme, the ICC/CM has access to external specialist advice from a GP and DHB infection control specialists when required. A documented Job description for the ICC including role and responsibilities is in place. Infection control reports are discussed at the staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits, and investigations, respectively. There are processes in place to isolate infectious residents when required. Adequate PPEs, hand sanitizers, and gels are available for staff and visitors to use. There have been no outbreaks documented and infection control rules are adhered to. Covid-19 precautions and guidelines for staff, visitors and families are in place. The staff interviewed demonstrated an understanding of the</p>

		Covid-19 precautions and ICP program. All residents' rooms included individual sink with soap liquid and soap bar for residents' use only.
<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	Janelle Rest Home infection prevention and control policies reflected the requirements of the infection prevention and control standards, Policies were reviewed and included appropriate referencing. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. The Care delivery, cleaning, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of PPEs.
<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	Monthly staff meetings address topical issues associated with infection prevention and control. If a resident is diagnosed with a certain type of infection, this is discussed by the registered nurse, identifying predisposing factors, treatment, and cares that are optimal and may reduce a recurrence of the infection, such as the residents' hygiene. Staff interviewed stated they had orientation and regular teaching regarding infection prevention and control techniques include PPE, hand hygiene and universal precautions This was reported by the ICC and confirmed with interviewed staff. Covid-19 information is shared and accessible to all staff to read. Residents are closely monitored for any signs and symptoms. Adequate Personal Protective Equipment (PPE) stock was sighted. Covid 19 information and posters for visitors and families placed around the facility.
<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	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 analysed to identify any significant trends or common possible causative factors and action plans are implemented. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a

		resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures regarding the use of restraint and enablers are developed in line with this standard and best practice. There are clear definitions for both restraint and enablers. All staff receives training regarding restraint and enabler use and the management of challenging behaviour. There were three enablers used as bed accessory, and no restraints were reported at the time of the audit.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>There are policies and procedures on restraint and enabler use, written information for residents and families on restraint and enabler use sighted. Clinical team in place review and approve a request for placing resident on restraint or enabler. Approvals taken from the clinical team include CM/restraint coordinator, owner/director (FM), GP signed on the restraint in use if required. EPOAs have signed for the enabler use. A restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. The register was reviewed and contained all 3 residents currently using enablers voluntarily.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint coordinator described that restraint can be used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment. Assessment is conducted before restraint use to include any potential risks, falls risk assessment, and behavioural challenges, nutritional and alternative interventions such as activities are documented. The assessment forms have been completed in all sample files and sighted. Restraint is part of orientation and training is provided annually or as necessary. Staff orientation and training on de-escalation intervention and behavioural challenges management are provided annually and through handover sessions, as required. Staff interviewed showed a good understanding of restraint and enabler use and care of residents with restraints.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The organisation's policies and procedures meet the requirements of the restraint minimisation and safe practice standards and guide the safe use of both restraints and enablers. The CM/ restraint coordinator has the qualification and training in restraints and enablers use. The approved restraint and enablers have been identified in the policy as side rails, and bed accessory staff are aware enabler must be the least restrictive and used voluntarily at a resident's request, the restraint can be used as a last resort when all alternatives have been explored and that this would trigger a referral for assessment., other alternatives considered in the assessment process such as floor crash mattress and regular visual checks. Approvals were obtained from the CM and restraint team before restraint was applied.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Review of residents' files showed that the individual use of restraints was reviewed, and evaluated during care plans, interRAI reviews, three- and six-monthly restraint evaluations, and at the restraint approval group meetings. The evaluation followed the policies and procedures and covers all requirements of this standard, including future options to eliminate use. Restraint audits were completed, and corrective action plans were implemented where required. Reviews of resident with restraint use include the monitoring of effect on resident and outcome and any relevant incidents reported, Restraint use competency assessments for staff were completed annually, current restraint competencies were sighted. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The clinical improvement team conducts a monthly review of all restraint use which includes all the requirements of this standard. Individual restraint use is reported in the quality and staff meetings held three monthly. Minutes of meetings reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, and the effectiveness of the restraint in use. Restraint use</p>

		monitoring and internal audits also informed these meetings. Any changes to policies, guidelines, education, and processes are implemented if indicated as reported by the restraint coordinator in the interview conducted.
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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 1.3.12.1</p> <p>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.</p>	PA Moderate	A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation to comply with legislation, protocols, and guideline	13 PRN Medication packs have no expiry dates.	<p>Provide evidence that PRN medications have expiry dates.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Low	The testing and tagging of electrical equipment and calibration of biomedical equipment is current as confirmed in documentation reviewed, interviews with the owner/director (FM), and observation of the environment. However, one resident’s refrigerator and microwave had not been tested and tagged.	Resident’s refrigerator and microwave have not been tested and tagged to certify it is safe for use.	<p>Ensure all equipment complies with legislation.</p> <p>90 days</p>

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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.