

Experion Care NZ Limited - Albany Home and Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Experion Care NZ Limited
Premises audited:	Albany Home and Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 13 July 2021 End date: 14 July 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	24

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Albany Home and Hospital provides rest home and hospital level care for up to 25 residents. There were 24 residents residing at the facility on audit days.

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

The residents and family members spoke positively about the care provided.

There were eight areas identified as requiring improvement relating to: quality and management systems, human resource management, medication management, resident menu plans facility specifications and essential and emergency systems.

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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Information regarding the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights, the complaints process, and the Nationwide Health and Disability Advocacy Service is accessible. This information is brought to the attention of residents and their families on admission to the facility. Residents and family members confirmed their rights are being met; staff are respectful of their needs and communication is appropriate.

The residents’ cultural, spiritual and individual values and beliefs are assessed on admission. Informed consent is practised, and written consent is gained when required. Services are provided that respect the independence, personal privacy, individual needs, and dignity of residents.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

There is a documented and implemented complaints management system. The facility manager is responsible for managing complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Experion Care New Zealand Limited is the governing body and is responsible for the services provided at this facility. The mission, vision and values of the organisation are documented and communicated to all concerned. There are systems in place for

monitoring the services provided, including regular reporting by the facility manager to the Experion Care New Zealand Limited owner and support office.

The facility is managed by an experienced facility manager with aged care experience, and they have been in this position since September 2020. The clinical lead is responsible for the oversight of the clinical services in the facility.

There is an internal audit programme, risks are identified, and a hazard register is in place. Adverse events are documented on accident/incident forms.

The appointment and management of staff is based on good practice and current practising certificates are kept on file.

Staffing levels and skill mix meet the changing needs of residents.

Resident information is accurately recorded, securely stored and not accessible to unauthorised people. The name and designation of staff making entries in clinical files are recorded and legible.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Registered Nurses are responsible for the development of care plans with input from residents, staff, and family member representatives. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems as they arise. Files reviewed demonstrated that the care provided and needs of the residents are reviewed and

evaluated. The planned activities programme provides residents with a variety of individual and group activities and maintains their links with the community.

There is a medicine management system in place, the service uses an automated medication chart system. The medicine charts had been reviewed by the GP at least three monthly or when required.

The food service is provided onsite and caters for residents, nutritious meals, snacks, and fluids are provided in line with recognised nutritional guidelines. Residents who require special or modified meals are reliably catered for. Snacks and drinks are available 24 hours for residents if needed. A food control plan was 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The building has a current building warrant of fitness displayed. There is a maintenance programme, and this includes a system for equipment and electrical checks. Fixtures, fittings, floor and wall surfaces are made of acceptable materials for this environment.

Residents' bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids, and to allow for care to be provided. Lounges, and dining areas, are available for residents and their visitors. External areas and gardens are safe for residents to mobilise around.

A call bell system is available to allow residents to access help when required.

Protective equipment and clothing are provided and used by staff. Chemicals are safely stored. The laundry is conducted on site. Cleaning of the facility is conducted by household staff and monitored.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation processes are in place. The Clinical Nurse Leader is the restraint coordinator. A risk register is maintained. There was one resident using restraint and one enabler at the time of the audit. The restraint policy outlines that the use of enablers shall be voluntary with the intention of promoting residents' independence and safety.

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.
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The infection control program is appropriate for the size, complexity and degree of risk associated with the service. The infection control nurse is responsible for coordinating, educating, and training staff. There are infection control policies and guidelines to guide the practice. Infection data is collated monthly and analysed. The infection control nurse uses the information obtained through surveillance to determine infection control activities and education needs.

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	5	0	0
Criteria	0	93	0	2	6	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>Policies, procedures, and processes are in place to meet the obligations in relation to the code of Health and Disability Services Consumers' Rights (the Code). (refer to 1.2.3.4). staff interviewed understood the requirements of the code. Staff were respectful of residents' rights as observed in their communications with residents and family members; encouraging residents' independence; and maintaining residents' dignity and privacy.</p> <p>Training in the code is included in the staff orientation process and part of the ongoing training (refer 1.2.3.4 and 1.2.7.5).</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices</p>	FA	<p>The residents' files evidenced consents using the organisation's standard consent form that includes consent for photographs, outings, and collection and sharing of health information. Consent is also obtained on an as-required basis, such as for influenza and covid 19 vaccinations.</p> <p>There was evidence of advance directives signed by the residents. Residents confirmed they were supported to make choices, and their consent was obtained and respected. Family members also reported they were kept informed about what was happening with their relative and consulted when treatment changes were being considered.</p>

and give informed consent.		Staff were observed gaining verbal consent for day to day care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on the advocacy service is included in the staff orientation programme and in the ongoing education programme for staff (refer to 1.2.7.5). Staff demonstrated understanding of the advocacy service, with contact details for the service readily available at the facility. Residents are provided with information on the advocacy service as part of the admission process. Residents and family members confirmed their awareness of the service and how to access this.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are encouraged to maintain their community interests and networks, and to visit with their families. The activities programme includes regular outings in the facility's hired mobility van and participation in community events. The service welcomes visitors and has unrestricted visiting hours. Family members advised they feel welcome when they visit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Policies and procedures relating to complaints management are compliant with right 10 of the Code (refer to 1.2.3.4). Systems are in place that ensure residents and their family are advised on entry to the facility of the complaints process and the Code. The complaints forms are displayed and accessible within the facility. Staff interviews confirmed their awareness of the complaints process. Residents and families demonstrated an understanding and awareness of these processes. The facility manager (FM) is responsible for complaints management. There have been no complaints received from external sources since the previous audit. A complaints register is maintained with all verbal complaints captured on a separate register. Both indicated no documented complaints since September 2020.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	During the admission process, new residents and their family are given a copy of the code and information on the Nationwide Health and Disability Advocacy Service. Posters on the code in English are displayed at the facility. Residents and family members interviewed were familiar with the code and the advocacy service. Residents

		and family stated they would feel comfortable raising issues with staff and management.
<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>Staff communicated their knowledge about the need to maintain residents' privacy and were observed doing so throughout the audit. The nurses' station is located, in the residents dining room. Residents' information and medication is located, in the same area (refer to 1.2.12.1). Staff interviewed understood the need to ensure residents files and information, including verbal was undertaken in a private manner.</p> <p>Residents are encouraged to maintain their independence by participating in community activities and outings, confirmed at resident and family interviews. Residents' care plans include documentation relating to residents' abilities and strategies to maximise independence. Residents' records sampled confirmed that residents' individual cultural, religious, social needs, values, and beliefs were identified, documented, and incorporated into their care plan.</p> <p>The policy on abuse and neglect was understood by staff interviewed, including what to do should there be any signs. Education on abuse and neglect is part of the staff orientation programme and in the mandatory staff study days (refer to 1.2.3.4, 1.2.7.3 and 1.2.7.5).</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 service has a Māori Health plan that guides staff in meeting the needs of the residents who identify as Māori (refer to 1.2.3.4). Any additional cultural support, if required, would be accessed locally, confirmed at clinical leader (CL) interview. At the time of the audit there was one resident who identified as Māori. The review of their clinical file and interview confirmed their individual cultural needs were being met.</p> <p>Family/whānau are able to visit their family members at the facility and are part of the care planning and evaluation of care process. Interviewed with family confirmed they were informed of their whānau member's changes in condition when this occurred and acknowledged and respected their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services</p>	FA	<p>The individual preferences, values and beliefs of residents are documented in the care plans reviewed. Residents and family members stated they had been consulted about residents' individual ethnic, cultural, spiritual values, and beliefs, and confirmed that these were respected.</p>

which 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>Residents and family members stated that residents were free from any type of discrimination or exploitation.</p> <p>Staff are guided by policies and procedures and communicated understanding of what would constitute inappropriate behaviour and the process they would follow should they suspect this was occurring (refer to 1.2.3.4).</p> <p>Staff orientation includes information related to all forms of discrimination and exploitation, professional boundaries and expected behaviours (refer to 1.2.7.5).</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 evidence-based policies and the comprehensive education schedule (refer to 1.2.3.4 and 1.2.7.5).</p> <p>The service encourages input from external specialist services and allied health professionals, for example palliative care specialists and wound care specialists. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</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>A review of accident/incident forms showed timely communication with residents and or family members. Communication with family members is also recorded in the clinical files reviewed at audit. The residents and family members stated they were kept informed about any changes to their own or their relatives' status and were advised about accidents or incidents and the outcomes of medical reviews. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff, residents, and family members interviewed reported meetings have not been held since September 2020 (refer 1.2.3.6).</p> <p>Staff interviewed reported interpreter services can be accessed via the district health board (DHB) or Interpreting New Zealand when required.</p>
<p>Standard 1.2.1: Governance</p>	FA	<p>Albany Home and Hospital (AHH) is part of the Experion Care New Zealand Limited (EC) group. A facility manager (FM) oversees the management of the facility. The FM provides regular emails and has regular phone</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>calls to the EC director who currently resides overseas.</p> <p>There is a clear mission of the organisation with values and goals and these are communicated to residents, staff, and family through a poster on the entrance to the facility.</p> <p>The FM is responsible for the overall management of the service and has been in this role since September 2020. The FM is supported by a clinical nurse lead (CNL) who is responsible for the oversight of clinical services. The CNL is an RN with experience in aged residential care. The CNL has been in the role since February 2021 and was previously employed as a RN. However, the CNL has resigned from the position and is currently completing her three months' notice. There have been no plans actioned to date, for a replacement.</p> <p>The facility can provide care for up to 25 residents, with 24 beds occupied at the audit. 20 rooms are designated as dual purpose and five rooms at rest home level care only. This included 13 residents requiring rest home level care, 7 requiring hospital level care. One resident was under a palliative contract, and one resident on respite care. There were two residents on a long-term chronic condition contract at hospital level, one of whom was under 65 years of age.</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>	<p>FA</p>	<p>In the absence of the FM, the CNL or a casual RN who was the previous owner will carry out required duties under delegated authority supported by other rostered registered nurses. Other experienced managers from a sister EC facility can be called in to provide cover and oversight if required.</p> <p>Management interviewed reported the current arrangements work well.</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</p>	<p>PA Moderate</p>	<p>Albany Home and Hospital uses the Albany Home 2004 quality and risk management framework that is documented to guide practice.</p> <p>The service has not currently reviewed the Albany home 2004 organisational policies and procedures to support delivery of service, therefore policies and procedures are not current. Hard copies of the previous owners' policies are available to staff.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents and implementation of an internal audit programme. The June 2020 patient satisfaction survey was collated, and corrective actions where required implemented.</p>

improvement principles.		<p>Facility meetings such as resident, staff, health and safety infection prevention and control, restraint have not been conducted since September 2021.</p> <p>The organisation has a risk management programme in place. Hazards are addressed, and risks are minimised or isolated.</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>	FA	<p>Staff understood the adverse event reporting process and were able to describe the importance of recording near misses. Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident/incident forms are completed by staff who either witness an adverse event or were the first to respond. Accident and incident forms are reviewed by management and signed off when completed. The registered nurses (RNs) undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>Policy and procedures comply with essential notification reporting: for example, health and safety, human resources, and infection control refer to 1.2.3.4). The FM is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility: unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks: and changes in key clinical managers. Authorities have been notified of the appointment of the CNL and when RN coverage was unavailable for a shift.</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>	PA Moderate	<p>Human resources management policies and processes are based on good employment practice and relevant legislation (refer to 1.2.3.4). The selection and approval of all new staff is the responsibility of the FM. A sample of staff files reviewed (six) indicated the organisations policies and procedures were not consistently implemented and records maintained.</p> <p>Professional qualifications are validated and there are systems in place to ensure that annual practising certificate and practitioners' certificates are current. Current certificates were evidenced for all staff and contractors that require them. No staff has been employed for over a 12-month period therefore performance reviews had not been completed, this is planned to begin in September 2021.</p> <p>Interviews with health care assistants (HCA) confirmed new HCAs are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks including personal cares for residents. Health care assistants confirmed their roles in supporting and buddying new staff. Completed orientations were not signed in 3 of 6 staff files reviewed. (Sample extended to six to confirm nonconformity).</p> <p>There were three RNS, including the CNL, that were interRAI competent.</p> <p>The organisation has a mandatory education and training programme, which is linked to the orientation</p>

		package, however not all staff have attended the mandatory education and training requirements.
<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>Staffing levels meet contractual requirements. The FM, the CNL and a casual senior RN are available during the weekdays and on call after hours and weekends. Adequate on-site RN cover is a regional and a facility issue. The required authorities had been informed when there was insufficient RN coverage. Coverage was provided by usage of senior HCAs and the senior casual RN on call.</p> <p>RN's currently work 12 hour shifts to ensure adequate on-site RN cover, 7 days a week. Registered nurses are supported by sufficient numbers of HCAs.</p> <p>Rosters are completed by the FM and overseen by the CNL. Rosters sighted reflected that staffing levels meet resident acuity and bed occupancy.</p> <p>Residents and families reported staff provide them with adequate care. HCA reported there were adequate staff available and that they are able to get through their work.</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>All resident files are in hard copy and stored in the secured in the locked cupboard in the patients dining area. Entries are legible, dated and signed by the relevant staff member including designation. Individual residents' files demonstrate service integration. The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner.</p> <p>Electronic data is password protected and can only be accessed by designated staff. Archived records are held securely on site and are readily retrievable.</p> <p>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</p>	FA	<p>Admission information packs for Albany Home and Hospital are provided for families and residents prior to admission or on entry to the service. Level of care assessments are completed and confirmed by the (NASC) team. Assessments and entry screening processes are documented and clearly communicated to resident/family where appropriate, referral agencies and local communities. Family/whanau interviewed confirmed that they received information regarding the services to be provided. Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner.</p>

identified.		
<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>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</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>	PA Moderate	<p>The service uses an electronic medication chart. GP conducts three monthly reviews of medication sighted in all sampled medication charts; allergies are indicated. All medication packs are checked by the RN on delivery against medication charts every month. Medicines held in stock are checked every month and any expired medicines are returned to the pharmacy promptly. A registered nurse was observed administering medicines and complying with required medication protocol guidelines and legislative requirements. The CNL reported there no residents who self-administer medication. Self-administration process are in place if required. Weekly controlled drug stocktakes are conducted, monitoring of medication fridge temperatures and medication storage room is conducted, and records were sighted. Medications are stored securely in the medication trolley. The service does not store any vaccines onsite. The CNL reported annual medication competency is completed for all staff administering medications. There are no medication errors reported, process is in place if there is a medication error.</p> <p>An improvement is required to ensure medication management meets legislative and best practice requirements</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>Meals are provided on site, the main cook planning the menu, ordering supplies, and ensuring required food service standards are maintained. In the absence of the cook other kitchen staff members run the kitchen and prepare meals. All staff who work in the kitchen have had food safety training. The cook was familiar with the food service policies and procedures and was aware of the special dietary requirements of the residents. The registered nurse completes a dietary assessment on admission, which is reviewed at least six monthly, a copy of this is given to the kitchen. 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. The kitchen was sighted and was observed to be clean and tidy. All food stored in the fridge and freezer was covered and dated. Records sampled confirmed daily fridge and freezer temperatures were recorded, cleaning records were also sighted. Cleaning materials and products were kept separate to food stuffs. Food is ordered</p>

		<p>weekly, or as required. All food on site looked fresh, with no food seen expired. A valid food service plan certification sighted. Residents/families spoken to provided positive feedback about the food service.</p> <p>Timely review of menu by the registered dietitian could be improved.</p> <p>There are policies and procedures and a food training schedule in place (refer to 1.2.3.4 and 1.2.7.5)</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 service declines residents if there are no beds available or if the level of care required is outside of the scope of the organisation. Any person/s declined are advised as to the reason and referred to the assessment and referral agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<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 risk falls assessment, pressure area, dietary, oral, pain, and nutritional assessments. Files sampled evidenced ongoing assessment at six monthly periods and more frequently if required. A wound assessment tool was available for use, however there were no residents with wounds at the time of the audit. All resident files had interRAI assessments that had been completed within the past six months. Family members interviewed advised that they had been notified when an updated assessment had been completed. All files sampled had monthly recording of the resident's vital signs and weight. Residents with diabetes had regular blood sugar levels documented.</p>
<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 service long-term and short-term care plans are developed for acute and long-term needs. Care plans are resident-focused, goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Assessments were completed in a timely manner, the interRAI assessment process informs the development of the care plan. The residents and family/whānau interviewed confirmed care delivery and support is consistent with their expectations and plan of care. Staff interviewed reported they found the care plan helpful and guide the residents' care, the verbal and written handover that occurs at the beginning of each shift promotes continuity in care delivery.</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>	<p>FA</p>	<p>The documented Interventions in the long-term care plans and short care plans are adequate to address the resident assessed needs and desired outcomes /goals. 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 and records sighted. Monthly observations are completed and are up to date including weight, blood pressure monitoring, and blood glucose monitoring. Behaviour management plans are developed with multi-disciplinary input and describe types of behaviour, possible triggers, and interventions. The CNL and the GP initiate any specialist referrals to required health services. 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. There is adequate PPE in place. EPOA /families interviewed were satisfied with the information provided about the support available to residents in the community, confirmed care delivery and support by staff is consistent with their expectations. They were kept informed of any changes to the residents' health status. Resident files sampled recorded communication with EPOA/ family. Staff interviewed confirmed the interventions in the care plans.</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 planned activities are appropriate to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and preferences. Residents' activities assessment is completed within two weeks of admission in consultation with the family. Copy of the activities schedule provided to residents and displayed on the board in the resident's lounge for reminder. The activities are conducted by the activities coordinator with oversight from the CNL, activities coordinator formulates activities daily depending on the weather conditions, suggestions from family/whanau and events of the day. Residents' Sampled files have a documented activity plan that reflects their preferred activities of choice and are evaluated every six months or as necessary. There are planned activities and community connections that are suitable for the residents. The activities coordinator reported the activities provided are individualised to meet the individual special needs of young person with disabilities. Maori residents participate in the planned activities as per their choice and preferences, including family/whanau social activities. Family members interviewed reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>The residents' long-term care plans, InterRAI assessments, and activity plans are evaluated at least every six months and updated in a timely manner when there are any changes. Family/whanau, residents, and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short-term care plans are developed when needed, signed, and closed out when the short-term problem has been resolved. Activities care plan reviewed and current. The multidisciplinary review includes the family /EPOA and are conducted 3 monthly and if required. Pharmacist</p>

manner.		and allied health input are taken as relevant to the resident condition. In interviews conducted, the family members reported that they are kept informed of any changes identified in the care plan process.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There is a documented process for the management of all referrals. The service utilises a standard referral form when referring residents to other service providers. The CNL confirmed that processes are in place to ensure that all referrals are followed up accordingly. GP 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 nursing team or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended, and the resident transferred to the public hospital in an ambulance if required.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of waste and infectious and hazardous substances. 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 (refer to 1.2.7.5). Safety data sheets were available. Protective clothing and equipment appropriate to the risks associated with waste or hazardous substances being handled are provided and being used by staff.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their	PA Moderate	A current building warrant of fitness is displayed. The maintenance person (employed end of May 2021) is developing a maintenance programme based on the requirements of the building and the standards. Staff are aware of the processes of reactive maintenance requests to ensure timely repairs are conducted, confirmed by staff and maintenance interviews. The maintenance staff member confirmed the building is older and requires refurbishment and repainting in several places, such as internal doors and bathrooms. Observed at audit the refurbishment of these areas was being undertaken.

purpose.		<p>The testing and tagging of equipment and calibration of biomedical equipment was not current.</p> <p>The external areas are safely maintained and are appropriate to the resident group and setting. Residents are protected from risks associated with being outside. The gardens are maintained by the maintenance staff member.</p> <p>Staff interviews confirmed they have appropriate equipment to meet residents' needs. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>The facility van is owned by the previous owners and was being serviced and checked for legislative requirements on the day of audit.</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>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. The bathrooms have been placed on the maintenance schedule to ensure all fixtures, fittings, floors, and wall surfaces are constructed from materials that can be easily cleaned.</p> <p>Toilets and showers have a system that indicates if they are vacant or occupied.</p> <p>Hot water temperatures are monitored monthly. When there have been hot water temperatures above the recommended safe temperature, action is taken, and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.</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>	FA	<p>Residents' bedrooms are personalised to varying degrees. The bedrooms are single occupancy bedrooms. The 20 dual-purpose rooms are large enough to allow staff and equipment to move around safely and provide personal space for residents.</p>
<p>Standard 1.4.5: Communal Areas For</p>	FA	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. The residents dining room is shared as the nurses' station</p>

<p>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>(refer to 1.3.12.1). Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</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>Cleaning and laundry policies and procedures are available (refer to 1.2.3.4). Laundry is completed on site. Interview with the household staff member confirmed residents' personal clothes, such as woollen clothes are washed separately and the management of laundry including the transportation, sorting, storage, laundering and the return of clean laundry to the residents. There is a dirty clean flow provided in the laundry.</p> <p>The household member also does the cleaning and described the cleaning processes and the use of chemicals for cleaning purposes. There are safe and secure storage areas for cleaning equipment and chemicals and staff have access to these areas as required.</p> <p>A sluice room is available for the disposal of soiled water and waste. A recent infection prevention and control audit related to covid-19 planning and implementation by the DHB highlighted the sluice room does not meet current standards. The FM described planning has started for alterations to meet current standards.</p> <p>Residents and family meetings have not been held to ascertain satisfaction with the laundry and cleaning of services (refer to 1.2.3.6).</p> <p>The effectiveness of the cleaning and laundry services is audited via 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>	<p>PA Moderate</p>	<p>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. Training and fire evacuation required under health and safety is yet to occur. The orientation programme includes fire and security training. (refer to 1.2.7.5). Staff confirmed their awareness of the emergency procedures.</p> <p>There is emergency lighting, gas for cooking, emergency water supply, blankets in case of emergency. Emergency equipment accessibility, storage and stock availability is to a level appropriate to the level of the number of residents.</p> <p>The call bell system in place is used by the residents, and/or staff and family to summon assistance if required and is appropriate to the resident groups and settings. Call bells are accessible/within reach and available in resident areas.</p>

		Staff interviews confirmed security systems are in place and staff are aware of security processes.
<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 comfortable temperature.</p>	FA	<p>Residents are provided with adequate natural light and safe ventilation. Residents and families confirmed the facility is maintained at a safe and comfortable temperature.</p> <p>Individual rooms are heated with adjustable heating panels. Common areas night stores. On the days of the audit the indoor temperature was comfortable.</p> <p>Residents and families confirmed the facilities are maintained at a comfortable temperature during the summer and winter months.</p>
<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 ICC is an RN assigned to the program is responsible for the infection control programme. There are 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 (refer 1.2.3.4 and 1.2.3.6). 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 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>Albany Hospital and Home infection prevention and control manual is available to guide staff and to ensure the IPC standards are effectively met (refer to 1.2.3.4). The ICC is responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Collation, analysis, and reporting of infection are completed and discussed at three monthly staff and management meetings (refer to 1.2.3.6).</p> <p>The ICC reported resources in place to manage the program through covid -19 restrictions period, adequate PPEs sighted on the audit day; disinfectant gel distributed around the facility. The ICC has access to all relevant resident data to undertake surveillance, internal audits, and investigations, respectively. Staff interviewed reported sufficient resources and disposable items for daily use, and adequate during last covid-19 restrictions level.</p>

<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 and procedures reflect the requirements of the infection prevention and control standards and current accepted good practice (refer to 1.2.3.4). Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff demonstrated knowledge on the requirements of standard precautions and able to locate policies and procedures.</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>The CNL reported staff education on infection prevention and control is conducted during handover session and online education resources, the CNL attends the regional infection control and prevention college meetings and provided information and updates to the ICC and staff. The training education information pack is detailed and meets current best practices and guidelines (refer to 1.2.3.4 and 1.2.7.5). External contact resources included the GP, laboratories, and local district health board specialist nurse. The ICC and staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice, there is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained.</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>A surveillance program has been implemented and documented. Infection surveillance practice, activities, and outcomes are well documented and supported with evidence of compliance sighted. Recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported in a timely manner. The CNL and ICC oversee the program and staff are informed of surveillance outcomes. Graphs and charts used to present results and benchmarking done through comparison with the previous period. An infection report is completed, and infections are signed off when resolved. Antibiotic usage is monitored and documented through infection reports. The infection register was sighted and is completed monthly. Hand washing audits are completed annually. An infection control annual report was completed. There were no infection outbreaks reported since the last audit. This is not reported through to management</p>

		and at staff meetings (Refer to 1.2.3.6).
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The CNL is the restraint coordinator, provides support and oversight for enabler and restraint management in the facility (refer to 1.2.7.3). On the day of the audit, one resident on enabler bed accessory. Use of enablers is voluntary for the safety of residents in response to individual requests. One resident was on restraint as a lap belt. A comprehensive assessment, approval, and monitoring process with regular reviews occurs. The restraint coordinator reported restraint is part of orientation and training is provided annually or as necessary (refer to 1.2.7.5). Approved restraint includes bed rails and lap belts. The staff interviewed were clear regarding the difference between restraint and enabler use.</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>The CNL /restraint coordinator provides support and oversight for enabler and restraint management in the facility. A restraint register is maintained, updated every month, and reviewed at each restraint approval group meeting. The register was reviewed and contained residents currently using a restraint and enough information to provide an auditable record. Staff are aware enablers 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 this would trigger a referral for assessment. The restraint in use lap belt have been approved by the Restraint team. The bed rails used for safety of residents due to frequent falls as described by the Restraint Coordinator. The assessment forms have been completed, approvals taken from the Quality and resident safety team include facility manager. Restraint coordinator and GP signed on the restraint in use as evidenced by records sighted. EPOA have signed consent for restraint use. Staff interviewed shown good understanding of restraint and enabler use, and care of resident with restraint. The restraint coordinator reported restraint is part of orientation and training is provided annually or as necessary. No training records were sighted (refer to 1.2.7.5).</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>Review of residents' file showed required assessments were completed prior to restraint use and on regular intervals. Risks related to the use of restraint have been identified, falls risk assessment identified high risk for falls. Pain, continence, dietary, skin, and behavioural assessment conducted. The assessment forms have been completed, signed by the restraint coordinator /RN. Approvals taken from the quality and resident safety team include facility manager, CNL/restraint coordinator, RN and GP reviewed and signed on the restraint in use as evidenced by the medical notes and records sighted. EPOA have signed fully completed consent for restraint use. The restraint use, desired outcomes evaluated in the care plan, and interRAI review. evaluation covers all requirements as per policy include options to eliminate use.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<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 prior to restraint use to include any potential risks, falls risk assessment, any behavioural challenges, nutritional and alternative interventions such as activities are clearly documented. The assessment forms have been completed in all sample files by the CNL/restraint coordinator and GP review sighted, Restraint register maintained and sighted. The Restraint Coordinator reported 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 is provided annually and through handover sessions as required (refer to 1.2.7.5). Staff interviewed indicated a good understanding of restraint and enabler use, and care of resident with restraints.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The evaluation process covers all requirements of this standard, including future options to eliminate the use, and reduce the impact the restraint had on resident, the support provided, safety precautions, and outcomes achieved. Restraint audits were completed, and corrective action plans were implemented where required. Monitoring of residents with restraint and enabler completed by the care staff on regular basis. A review of residents' files and restraint records showed that the individual use of restraints was reviewed and evaluated during care plan, interRAI reviews, three and six-monthly restraint evaluations, and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process, that includes behavioural assessment, culturally safe practice. Long term care plans include restraint expected goals and interventions.</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>	<p>FA</p>	<p>The quality improvement committee conducts a three-monthly review of all restraint use which includes all the requirements of this standard. Individual restraint uses and monitoring results are reported in the quality and staff meetings every two months (refer 1.2.3.6). Restraint records reviewed confirmed this included analysis and evaluation of the amount and type of restraint used in the facility, whether all alternatives to restraint have been considered, and the effectiveness of the restraint in use, as evidence sighted. Restraint use competency assessments for staff were completed annually as reported by the restraint coordinator. Any changes to policies, guidelines, education, training needs, and processes are implemented if indicated, as reported by the restraint coordinator during interview. The service copy with restraint policies and procedures as sighted (refer 1.2.3.4).</p> <p>Staff training to be recorded and maintained (Refer 1.2.7.5)</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	PA Low	<p>Albany Home and Hospital uses the Albany Home 2004 quality and risk management framework that is documented to guide practice.</p> <p>The service has not currently reviewed the Albany home 2004 organisational policies and procedures to support delivery of service, therefore policies and procedures are not current. Hard copies of the previous owners' policies are available to staff.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents and implementation of an internal audit programme. The June 2020 patient satisfaction survey was collated, and corrective actions implemented where required.</p> <p>Facility meetings such as resident, staff, health and safety infection prevention and control, restraint have not been conducted since September 2020</p> <p>The organisation has a risk management programme</p>	<p>(i)there is no documented evidence the policies and procedures have been reviewed or updated since the change of ownership.</p> <p>(ii)Policies were noted not to have a date to reference as to date of review or authorisation</p> <p>(ii)Polices referred to an email address which is the previous owners contact details</p> <p>(iv)There were a number of versions of</p>	<p>Ensure all policies and procedures are managed to ensure all documents are approved, up to date and a system is introduced to manage the use of obsolete documents.</p> <p>180 days</p>

		in place. Hazards are addressed, and risks are minimised or isolated.	the same policy with no indication which was the current policy (v)The restraint policies were dated last reviewed 2017.	
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Discussion with staff, residents, family members and the FM reported there have been no formal meetings since the change of ownership in September 2020. Quality data such as audits, accident/incidents, infection prevention and control data is collected. However, this is not communicated to the residents, staff or EC management. All staff reported informal meetings are held and family and residents reported they were aware of the happenings at the facility.	There have been no official meetings held at the facility since the change of ownership. This includes, resident, staff, health and safety, infection prevention and control, restraint and quality improvement.	Provide evidence formal meetings are held regularly and document evidence that information has been provided to key stakeholders. 60 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	There are inconsistencies in the required documentation of human resources, to ensure all documentation and practices align with legislation and good employment practices. The FM explained recruitment and retention of staff especially registered nurses has been an issue since September 2020. This is a regional issue highlighted since covid 19 border controls. This has impacted on the service with the number of new staff and the recent high turnover of staff. On interview the infection prevention and control co-ordinator was unaware of the existence of a position description.	(i)there was no evidence of police checking for any new employee (ii)Registered nurses have been allocated the positions of infection prevention and control and restraint coordinators: however, positions descriptions were not evident in the staff members files.	Ensure human resource management processes meet current good employment practice. 60 days

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>There is an orientation process in place for all staff. Three of six staff files reviewed did not have recorded evidence of orientation. This included the new maintenance person, the clinical nurse lead, and an HCA. The orientation programme includes mandatory training such as fire drill, handwashing infection control and manual handling.</p> <p>There is a mandatory education schedule that covers the requirements of the standard and includes training for medication and first aid competencies. Staff had attended training for first aid and medication competencies.</p>	<p>(i)Not all staff have completed the required orientation programme.</p> <p>(ii)not all staff have competed the mandatory annual training and education</p>	<p>Provide evidence all staff have completed the required orientation programme and mandatory training requirements.</p> <p>90 days</p>
<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>	<p>PA Moderate</p>	<p>The service uses an electronic medication chart. There is facility designed medication administration form, details handwritten by nurses from discharge summary /discharge prescription and used temporarily to administer and sign medications until medication charted by GP in the Medication administration electronic system. Transcribing records sighted at Audit. it is evident that Registered Nurses currently transcribe medications.</p> <p>A registered nurse was observed administering medicines and complying with required medication protocol guidelines and legislative requirements. In review of sample medication chart, it is evident outcome of PRN medications not documented for effectiveness.</p> <p>GP conducts three monthly reviews of medication sighted in all sampled medication charts; allergies are indicated, however in seven of medication chart sighted no entry made in for residents with No known Drug Allergies (NKDA), Un known Allergies not documented for residents with no allergies.</p>	<p>(i)Registered Nurses currently transcribe medications.</p> <p>(ii) outcome of PRN medications not documented for effectiveness.</p> <p>(iii)six monthly stocktaking of controlled drugs has not been completed.</p> <p>(IV) Un known Allergies, No known Drug Allergies (NKDA) not documented for residents with no allergies</p> <p>(V) Medication was stored in the food fridge.</p> <p>(VI) Controlled drug was</p>	<p>Ensure all medication management process meets legislative and best practice requirements:</p> <p>90 days</p>

		Medications are stored securely in the medication trolley. On checking the food storage fridge at Audit, two packs of medication seen stored in the food fridge. During audit check it was sighted that controlled drug stored in locked wooden cupboard located in the resident dining room, not in a compartment that was constructed of metal or concrete.	stored in locked cupboard in the residents dining room, not in a compartment that was constructed of metal or concrete.	
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	The cook was familiar with the food service policies and procedures and was aware of the special dietary requirements of the residents. The registered nurse completes a dietary assessment on admission, which is reviewed at least six monthly, a copy of this is given to the kitchen Dietitian review of the seasonal menu have been sighted, however no review by registered dietitian since 2018.	The menu has not been reviewed by the registered dietitian since 2018	Ensure menu is reviewed every two years by a registered dietitian, to comply with recognised nutritional guidelines 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	A system and processes has been developed to ensure the testing and tagging of equipment and calibration of biomedical equipment is current. A confirmation from the contractors apologised for the delay in completing the request work, this was related to covid -19 and the need to adjust the timetable for completion. This has been booked for completion on 26th July 2021	The testing and tagging of equipment and calibration of biomedical equipment was not current.	Ensure the testing and tagging of equipment and calibration of biomedical equipment is current. 30 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and	PA Moderate	The fire evacuation scheme and documented systems and processes are no longer current (refer to 1.2.3.4).. The FM reported the local fire risk and management office is working with the service to update the fire evacuation plan and ensure an onsite trial is held in	i) There is no fire evacuation scheme that meets current legislation ii) There was no documented evidence of	Ensure the fire evacuation scheme and six-monthly fire evacuations are completed as per

<p>security situations. This shall include fire safety and emergency procedures.</p>		<p>October 2021. Sighted at audit the email from the local fire risk management officer confirming the action plan and a review of the fire evacuation scheme and processes.</p> <p>The service has completed an inhouse fire evacuation training on 15/4/2021.</p>	<p>formal fire evacuation training had occurred since July 2019 as per legislation.</p>	<p>legislation.</p> <p>30 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.