

Living Waters Medical Solutions Limited - Living Waters Rest Home

Introduction

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

The audit has been conducted by BSI Group New Zealand Ltd, 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: Living Waters Medical Solutions Limited

Premises audited: Living Waters Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 20 January 2022 End date: 20 January 2022

Proposed changes to current services (if any): Please note – The name of the facility has changed to Living Waters.

Total beds occupied across all premises included in the audit on the first day of the audit: 16

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
Yellow	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
Red	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

Living Waters provides rest home level care for up to 21 residents. On the day of the audit there were 16 residents requiring rest home level of care.

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

A facility manager (non-clinical) with experience as a general practice manager oversees the service and is supported by a clinical nurse manager (CNM). Residents, relatives, and the general practitioner (GP) interviewed spoke positively about the service provided.

This audit has identified eight shortfalls around the following: cover for the clinical nurse manager when on leave, the quality programme, notification to Worksafe when required, reference checking, performance appraisals, staffing, neurological observations, and hot water temperatures.

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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Living Waters provides care in a way that focuses on the individual resident. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural and spiritual needs of residents are met. Policies are implemented to support residents' rights, communication, and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

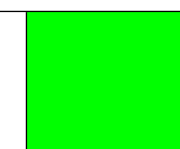
Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Policies and procedures are maintained by an external aged care consultant who ensures they align with current good practice and meet legislative requirements. The quality and risk management programme includes service philosophy, goals, and quality indicators. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held

with data tabled. Residents/family meetings have been held monthly. Health and safety policies, systems and processes are documented.

There are human resource policies in place. An education and training programme has been implemented with a current training plan in place and competencies relevant to carer roles completed. Rosters are documented.

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.		Standards applicable to this service fully attained.
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A Living Waters welcome pack is provided to family and residents prior to or on entry to the service. The clinical nurse manager and enrolled nurse are responsible for each stage of service provision. The CNM is responsible for all aspects of care planning, assessment and evaluation of care with the resident and/or family input. Care plans reviewed in resident records demonstrated service integration and were evaluated at least six-monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The CNM, enrolled nurse and medication competent caregivers are responsible for administration of medicines and complete annual education and medication competencies. The electronic medicine charts reviewed met legislative prescribing requirements and were reviewed at least three-monthly by the general practitioner.

The diversional therapist provides and implements the activity programme with support from a volunteer and caregivers. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Residents commented very positively on the meals provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is a registered first aider on each shift.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint, should this be required. Staff receive regular education and training on restraint minimisation and management of challenging behaviour. No restraint or enabler was in use on the day of audit. Living Waters has been restraint free for eight years.

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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There is a suite of infection control policies and guidelines to support practice. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical nurse manager is responsible for infection control. The infection control coordinator has a job description and has attended external education within the past year. Staff complete annual competencies related to infection control.

Surveillance data is documented. There have been no outbreaks. A pandemic plan was actioned, and Covid 19 policies and procedures have been developed and continue to be implemented.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	39	0	4	2	0	0
Criteria	0	85	0	6	2	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>A policy relating to the Code of Health and Disability Services Consumer Rights (the Code) is implemented. Leaflets on the Code are accessible to residents and their families. Staff receive training about the Code during their induction to the service, with this provided annually through the staff education and training programme. A staff education session on the Code was held in July 2021.</p> <p>The facility manager, clinical nurse manager (CNM) and staff interviewed (three caregivers, one cook, and the diversional therapist) could describe how the Code is incorporated into their everyday delivery of care.</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 and give informed consent.</p>	FA	<p>There are established informed consent, resuscitation and advanced directives policies/procedures. All five resident files including one younger resident under Ministry of Health (MOH) funding contained written consents. General written consents are obtained on admission including photos, name on door, sharing of information, outings and transport. Specific consents are obtained for specific procedures such as influenza and Covid vaccinations.</p> <p>Resuscitation status had been signed appropriately. Advance directive care plans were signed for separately and sighted in all five resident files. Copies of enduring power of attorney (EPOA)</p>

		<p>where available were in the residents' files. The EPOA had been activated for residents deemed incompetent to make health related decisions.</p> <p>Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The caregivers and clinical nurse manager interviewed, demonstrated a good understanding in relation to informed consent and informed consent processes.</p> <p>Family and residents interviewed, confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided on admission.</p> <p>Five long-term resident files reviewed had signed admission agreements. There is a respite/short stay admission agreement used for short-term stay. The agreements include permissions granted.</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>	FA	<p>Health and Disability advocacy brochures are included in the information provided to new residents and their family/whānau during their entry to the service. The complaints process is linked to advocacy services. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Residents and family interviewed were aware of the role of advocacy services and their right to access support if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service encourages their residents to maintain their relationships with friends and community groups. Residents may have visitors of their choice at any time. Assistance is provided by the caregivers to ensure that the residents continue to participate in their chosen community group. There are a number of community visitors to the facility in accordance with Covid 19 regulations. The service is gradually re-introducing entertainers into the service so long as they are fully vaccinated.</p> <p>The diversional therapist (DT) is available to take residents on community visits and staff are available to take people to appointments if family are not able to provide transport.</p> <p>Residents interviewed, confirmed they can have access to visitors of their choice at any time and are supported to access services within the community. There were a large number of family visiting on days of the audit.</p>
Standard 1.1.13: Complaints	FA	Complaints forms are available at the front entrance to the facility. Information around the

<p>Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>complaints process is provided on admission and is included in the admission pack. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register.</p> <p>There was one complaint in 2021 and one complaint in January 2022. Both complaints were received since the last audit. Documentation and correspondence reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Staff interviewed confirmed that complaints were discussed at the staff meetings. Complaint documentation requiring changes to care planning are signed by staff once read. Residents and relatives advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The CNM discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the resident/family meetings.</p> <p>Five residents and four relatives interviewed reported that the residents' rights were being upheld by the service.</p>
<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>The residents' rooms are personalised and decorated to the residents' individual taste with their belongings. The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms and this was demonstrated on the day of audit. Caregivers confirmed they promote the residents' independence by encouraging them to be as active as possible. Residents and relatives interviewed and observations during the audit confirmed that the residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect annually with this on the training plan to be held this month. The staff interviewed can fluently describe examples of abuse and signs and symptoms residents may portray.</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</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. The staff interviewed were knowledgeable around Māori culture and practices.</p>

<p>acknowledges their individual and cultural, values and beliefs.</p>		<p>Living Waters has access to a cultural advisor from Te Ara Toiora (Te Oranganui Iwi Health Authority). Maori language week is recognised in the activities programme. The local kaumatua is invited to bless rooms following a resident's death, and staff are invited to join in with the blessing and karakia.</p> <p>There were no residents who identified as Māori on the day of the audit. One staff member identifies as Maori and some staff are able to speak some te reo Maori. Staff education on cultural awareness begins during their induction to the service and continues annually, with this last held in November 2021. All staff complete a cultural competency (sighted on files reviewed for staff who have been in the service for more than three months).</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>	<p>FA</p>	<p>The CNM and/or enrolled nurse at Living Waters identify the residents' personal needs, culture, values and beliefs at the time of admission. This is achieved in collaboration with the resident, whānau/family and/or their representative. Beliefs and values are incorporated into the residents' care plans in resident files reviewed. Residents and family/whānau interviewed confirmed they were involved in developing the resident plan of care, which included the identification of individual values and beliefs.</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>The service has a staff code of conduct, which states there will be zero tolerance against any discrimination occurring. The CNM and facility manager supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them and that there was no evidence of discrimination.</p> <p>Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are comprehensive policies and procedures, and a staff training programme which covers all aspects of service delivery. Internal auditing programmes are implemented. External specialists such as wound care specialist, nurse practitioners, and continence nurse were used where appropriate. The general practitioner (director) is also able to provide support and advice if required. The facility manager is also a practice manager and is able to access support from the medical centre if required.</p> <p>There is an active culture of ongoing staff development with the Careerforce programme being</p>

		<p>implemented. There is also access to training at the district health board for the CNM. There are implemented competencies for caregivers and the CNM. There are clear ethical and professional standards and boundaries within job descriptions.</p> <p>Resident, relatives and the general practitioner (GP) interviewed were very complimentary about the care and support provided. Staff stated that the general practitioner who visits the service provides them with information and support whenever required. The general practitioner interviewed stated that the service provided a high quality of care.</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 a policy to guide staff on the process around open disclosure. Residents and relatives interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry. The CNM and facility manager operate an open-door policy.</p> <p>Fifteen incident/accident forms reviewed from November 2021 to January 2022 identified the next of kin (NOK) were notified following a resident incident. The relatives interviewed confirmed they are notified promptly of any incidents/accidents with examples given of when they had been rung. Interpreter services are available if required.</p> <p>The service had raised money and purchased an iPad so residents could keep in touch with families during the lockdown period. Family members stated that they were kept fully informed around changes in visiting hours and expectations related to Covid 19. They also stated that the service had kept in touch with them during lockdown around their family member.</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>Living Waters provides care for up to 21 rest home level residents. There were 16 permanent residents on the day of the audit including two residents under a YPD (young person with a disability) contract. All other residents were under the Aged Residential Related Care (ARRC) contract. There were no residents on an intermediate care or respite contract.</p> <p>The service has a strategic plan and a 2022 quality and business plan which includes the mission, philosophy, and goals with actions for the following year. Aims and ambitions for the 2021 year have been signed out as being resolved. The facility manager states that the goals for 2022 will be reviewed annually with input from the other director.</p> <p>The facility manager (director) is non-clinical and has a background in practice management (GP practice) for three years, with a further 12 years' experience in correctional facilities. They have completed more than eight hours of training relevant to the role. The facility manager is supported by the clinical nurse manager (CNM) who has 11 years' experience in aged care nursing including</p>

		<p>previous experience as a unit manager. They have an annual practicing certificate and have completed in excess of eight hours of professional development in the past 12 months. The other director is a GP who visits the practice to provide medical care to residents.</p> <p>Both the facility manager and the CNM started in the role in March 2021 following the sale of the facility.</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>	PA Low	<p>Interviews with the facility manager confirmed that the CNM and facility manager are on call alternatively after hours. The CNM is expected to provide cover for the facility manager in a temporary absence. There is no back up registered nurse in place should the CNM be on leave.</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>	PA Low	<p>Living Waters is implementing a quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. These are checked by an aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements. All policies have been reviewed in January 2022.</p> <p>An internal audit programme is in place that includes aspects of clinical care. Issues arising from internal audits are either resolved at the time or developed into a quality improvement plan. The closure of corrective actions resulting from the internal audit programme was recorded. The closure of corrective actions resulting from the internal audit programme was recorded, signed off by the facility manager or CNM.</p> <p>A record of monthly risk identification, and quality indicators is maintained and tabled at the monthly meetings. A copy is filed with the completed monthly internal audits. Monthly accident/incident reports and infections is graphed and the CNM reviews this. Quality matters are taken to the monthly combined staff/quality meetings which includes health and safety and infection control. Quality/staff meeting minutes do not evidence discussion of data and improvements made as a result of that discussion. Staff interviewed state that there was discussion at the meetings.</p> <p>Resident meetings have occurred six-weekly in the past. The diversional therapist (DT) is moving these to two-monthly, as there is a limited number of residents who wish to come to meetings.</p>

		<p>Family are invited to attend.</p> <p>Satisfaction surveys are held annually and include resident, relative, and staff satisfaction. There is also a separate resident privacy audit, activities survey and nutritional survey completed by residents. The resident satisfaction survey identified that 91% of residents are satisfied with the service. The 2021 identified that 95% of residents were satisfied however this was prior to the new owners being in place. The relatives' satisfaction survey identified that 98% were satisfied with the service. There were no areas consistently raised for improvement in either survey.</p> <p>The risk management plan is in place. The facility manager has taken on the role of health and safety representative and is committed to completing health and safety training (link 1.2.4.2). Staff receive health and safety training during orientation and ongoing and each completes an annual competency around health and safety. Health and safety is discussed and documented in the monthly quality/staff meetings. Actual and potential risks are documented on the hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. The register is up-to-date and was reviewed at the end of 2021. Falls management strategies include wireless sensor mats, and the development of specific falls management plans to meet the needs of each resident who is at risk of falling.</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>PA Moderate</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports related to residents are completed for each incident/accident with immediate action noted including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. Fifteen accident/incident forms were reviewed with each incident involving a resident clinical assessment and follow-up by a registered nurse. Neurological observations were conducted for suspected head injuries; however, these were not always completed as per policy.</p> <p>The CNM and facility manager reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. One notification has been made for a fracture for one resident since the last audit, however, the service has not reported a serious staff incident to Worksafe, HealthCERT or the DHB.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>PA Low</p>	<p>There are human resources policies to support recruitment practices. Five staff files sampled (facility manager, CNM, one enrolled nurse, one caregiver, one diversional therapist) contained documentation apart from evidence of reference checks and evidence of performance appraisals completed annually. Current practising certificates were sighted for the CNM and allied health</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme covering all the relevant requirements is implemented. Attendance records evidence good attendance at education. Staff have the opportunity to attend external education and online training is monitored by the CNM. Care staff complete competencies relevant to their role, including medication competencies, manual handling, restraint, pain, culture, hydration and nutrition, infection control, health and safety and wound care. All staff have current first aid certificates apart from very new staff.</p> <p>Of the 10 caregivers in the service, there are five with level 2 New Zealand Qualification Authority (NZQA) through Careerforce training; three with level three and two in training; and two with level four with one in training. The kitchen staff have food handling certificates. There is one enrolled nurse who has completed relevant competencies.</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>PA Moderate</p>	<p>Living Waters has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager works five days a week (Monday to Friday) and is supported by the CNM who works 40 hours a week. The managers share the on-call load with this clearly designated on the roster re who is on call. The caregivers interviewed stated that the one manager was difficult to get hold of when on call and the facility manager confirmed awareness of this.</p> <p>They are supported by the following caregivers:</p> <p>On the morning shift, there is one caregiver from 7am to 3pm, one 7am to 11am, and one from 7.30am to 1.30pm. There is one caregiver in the afternoon from 3pm to 8pm, one from 4pm to midnight and overnight there is one caregiver form midnight to 8am. There is a kitchen assistant who comes in to help with feeding residents in the evening.</p> <p>Residents and family stated that they thought that staff were working very hard and struggling to catch up on some tasks although all stated that cares were completed. The rosters from November to date (January) indicated that when staff where on leave, they had not always been able to be replaced.</p>
<p>Standard 1.2.9: Consumer Information</p>	<p>FA</p>	<p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into each resident's individual record. Information containing personal resident information is</p>

<p>Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked area. The residents' files are appropriate to the service type. Residents' files demonstrate service integration. Entries are legible, dated, timed and signed by the relevant caregiver or RN, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There are policies in place for entry into the service. This is facilitated in a competent, timely and respectful manner. Admission information packs on the service are provided for families and residents prior to admission or on entry to the service. Admission agreements reviewed aligned with all contractual requirements. Exclusions from the service are included in the admission agreement.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exits or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The clinical nurse manager, enrolled nurse (EN) and senior caregivers who administer medications complete annual medication competencies and education. The medication storage areas are secure. Medications (blister packs) are checked on delivery by the clinical nurse manager or EN against the electronic medication chart and verified on the medication system. Any discrepancies are fed back to the pharmacy. Standing orders are not used. There is no impress stock held. There were no self-medicating residents. The medication fridge is monitored each night and within acceptable limits. The medication room air (nurses' station) is monitored daily and identified corrective actions for temperatures above 25 degrees Celsius. All eyedrops were dated on opening.</p> <p>Ten medication charts were reviewed on the electronic medication system. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three monthly. As required medications had indications for use and administered as prescribed. The effectiveness of as required medications was documented in the electronic medication system and in the progress notes.</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>Meals are prepared in a homely open plan kitchen adjacent to the dining room and served directly to the residents. The head cook works from Wednesday to Sunday from 8am to 2pm. The head cook is supported by a second cook on Mondays and Tuesdays. Food services staff have attended food safety training. The six weekly menu dietitian review is booked February 2022. The menu includes pureed and vegetarian meals. The main meal is at midday with a savoury meal in the evening. The cook receives a nutritional profile for each resident and is notified of any dietary changes. Special diets include a gluten free diet. Dislikes are known and accommodated. A kitchenhand is on duty from 5-7pm to heat and serve the prepared evening meal.</p> <p>The service has a current food control plan which expires 1 June 2022. Fridge, freezer and chiller temperatures are monitored and recorded daily. End-cooked temperatures are taken and recorded. Cooling temperatures are recorded. The thermometer probe is calibrated. Temperatures of inward goods are maintained. A cleaning schedule is maintained. The dishwasher has recently been replaced. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled.</p> <p>Resident meetings along with direct input from residents, provides resident feedback on the meals and food services generally. Residents and family members interviewed were very satisfied with the meals provided.</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>There are policies in place to guide practice. The reasons for declining entry would be if the service is unable to provide the level of care required or there are no beds available. The service communicates directly with the referring agencies and family/whānau as appropriate if entry was declined.</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>An RN or enrolled nurse completes an initial assessment and care plan (countersigned by the RN) on admission, including a clinical risk assessment and relevant risk assessment tools. Risk assessments are completed six-monthly. The interRAI assessment is completed within 21 days of admission and six monthly or earlier due to health changes. The outcomes of assessments form the basis of the long-term care plan.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Resident care plans reviewed were resident focused and included medical needs, daily activities of living and care needs and supports. Acute plan of care (short-term care plans) is used for changes to health and were sighted in resident files. These are reviewed weekly and if the problem remains unresolved after six weeks this is added to the long-term care plan. All long-term care plans were current and up to date. The resident (as appropriate) and relative sign the front page of the care plan to acknowledge they had have read and discussed the care plan with the RN. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration.</p> <p>There was evidence of allied healthcare professionals involved in the care of residents including mental health services, needs assessment, dietitian, ACC physio, psychogeriatrican and podiatrist.</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>When a resident's condition alters, the clinical nurse manager or enrolled nurse initiates a review and if required, GP or nurse specialist consultation. There is documented evidence on the family contact form in each resident file that indicates family were notified of any changes to their relative's health including infections, accidents/incidents, GP visits, medication changes and referrals and appointments. Discussions with families confirmed they are notified promptly of any changes to their relative's health. Short term care plans are documented to monitor a resident progress against interventions for changes in health.</p> <p>Adequate dressing supplies were sighted in the nurse's station/treatment room. Wound management policies and procedures are in place. Wound assessment and wound management and treatment forms and ongoing evaluation forms were in place for three residents with wounds (two surgical, one lesion and two non-facility acquired healing stage 2 pressure injuries). There is access to a wound nurse specialist at the DHB if required.</p> <p>Continance products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Monitoring forms are used for weight, pulse, temperature and blood pressure recordings, neurological observations (link 1.2.4.3), pain, challenging behaviour, food and fluid charts, bowel monitoring and resident checks.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>The service employs a qualified diversional therapist (DT) who works from 9am to midday Monday to Friday. She has been in the role one week, completing her orientation and is booked for first aid</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>training. The DT does daily meet and greet with all residents and one-on-one activities such as individual walks, reading and chats, occur for residents who choose not to be involved in group activities. Care staff follow the DT guide for afternoon and weekend activities. There are plentiful resources available.</p> <p>The programme is planned a month in advance in consultation with the facility manager and resident feedback from the two monthly resident meetings. Many activities involving entertainers and community outings have been disrupted due to Covid restrictions.</p> <p>Regular activities include newspaper reading, exercises using the age concern falls prevention programme, board games, crafts, discussions and music. The facility has two home cats, but pet therapy has been on hold. There are monthly non-denominational services and weekly communion. Festive occasions and themes are celebrated. Families are invited to attend events.</p> <p>The service hires a 10-seater van for monthly outings, scenic drives and picnics. Two staff (the DT and the facility manager who has a current first aid certificate) accompany the residents.</p> <p>A diversional therapy assessment, map of life and Individual activity plans DT plan was completed in all files reviewed. They are reviewed in discussion with the clinical nurse manager, EN resident and families every six months. The two younger persons have individualised activity plans identifying their recreational preferences and one on one activities such as use of the iPad.</p> <p>The service receives feedback and suggestions for the programme through resident meetings, surveys and direct feedback from residents and families. There was positive feedback from residents and families about the activities programme which they have input into.</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>All initial care plans for long-term residents were evaluated by an RN or EN within three weeks of admission and long-term care plans developed. Long-term care plans have been evaluated by an RN or EN (countersigned by the RN) six monthly, using the interRAI tool or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes or the care plan. Care plans had been updated with any changes to health. Short-term care plans are reviewed weekly and either resolved or if an ongoing problem added to the care plan. The care plan evaluations identified if the resident goals had been met or unmet.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal</p>	<p>FA</p>	<p>Referral to other health and disability services is evident in the resident files reviewed. Examples of referral for a higher level of care were seen such as intermediate care to rest home care. The GP involves the resident (as appropriate) and relative in discussions around referrals and options</p>

<p>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>		<p>for care. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Safety datasheets are readily accessible for staff. Chemicals are stored in a locked cupboard in the laundry. There is a spills kit available. Chemical bottles sighted have correct manufacturer labels. A sluice tub is located within a shower area. Personal protective clothing is available for staff and was observed being worn by staff when they were carrying out their duties on the day of audit. All staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness that expires 22 June 2022. The facility manager oversees the repairs required and the 52-week planned maintenance plan. Staff complete forms for requests for repairs. Contractors complete planned maintenance as scheduled. Planned maintenance includes interior and exterior building, equipment checks, electrical checks and calibration of clinical equipment such as chair scales. Resident shower and handbasins temperatures are checked monthly however some temperatures are above 45 degrees Celsius. Essential contractors are available 24 hours. There is ongoing refurbishment including replacement of the heating system, replaced lighting and fittings throughout the facility, new medical equipment and replacement of appliances.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe ramp access to the deck and well maintained landscaped outdoor areas. Seating and shade are provided. A gardener is contracted fortnightly for lawns and gardens.</p> <p>The caregivers interviewed stated they have sufficient equipment including mobility aids, wheelchairs, chair scales and pressure injury resources (if required), to safely deliver the cares as outlined in the residents' care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And</p>	<p>FA</p>	<p>Bedrooms in two of the three wings have hand basins. Two rooms have a shared hand basin and toilet ensuite. There are adequate numbers of communal shower rooms and toilets (including a</p>

<p>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>disability toilet) in each wing. There are privacy curtains in showers and privacy locks or engaged/vacant signs on the doors. Residents confirmed staff respect their privacy while attending to their care.</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>All rooms are single. There is adequate room for residents to safely manoeuvre using mobility aids. Rooms viewed were personalized with residents own furnishings and adornments as viewed on the day of audit. Most resident rooms open out onto the deck with views of the garden.</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>Communal areas within the facility include a spacious dining area with doors that open onto the large deck area with outdoor tables and chairs. The lounge has an extension with a separate seating area and grand piano. The lounge also has door access to the deck area. There is a separate lounge that can be used for visiting and quieter activities. Communal areas are easily accessible to residents.</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>Policies and procedures provide guidelines regarding the safe and efficient use of laundry and cleaning services. Caregivers' complete laundry and cleaning duties as scheduled across the shifts. There is a designated laundry with a defined clean/dirty area. The laundry is locked and has an external door for ventilation and access to the clothesline. Linen and personal clothing is delivered to laundry in covered buckets where it is sorted. There are two washing machine and dryer is serviced regularly.</p> <p>The cleaner's trolley is kept in the laundry when not in use. There is a dispensing system for the re-filling of chemical bottles. Safety data sheets are available. Chemicals are kept in a locked cupboard in the laundry. There is protective personal clothing available. The effectiveness of the cleaning and laundry processes are monitored through internal audits, resident meetings and surveys. Residents and relatives interviewed were satisfied with the laundry service and cleanliness of the communal areas and their bedrooms.</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>Emergency, disaster policies and procedures are documented for the service. There is an approved fire evacuation scheme. Fire drills occur every six months (last fire drill occurred in October 2021). The orientation programme and annual education/training programme include fire and emergency procedure training. A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food and bottled water supplies to last for three days. A gas BBQ and gas hobs in the kitchen are available for alternate cooking during a power failure. Emergency lighting is in place. A call bell system is in place including all resident rooms and communal areas. The rest home is secure after hours. There is at least one staff member on duty with a current first aid certificate.</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 comfortable temperature.</p>	FA	<p>Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All bedrooms have adequate natural light. The furnace and heating system has been replaced. There is underfloor heating which is centrally controlled. Each resident room has a floor vent for heating. There are gas log fires in the two lounges.</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 CNM is responsible for the infection control (IC) programme. Responsibility for infection control is described in the job description. The infection control coordinator oversees infection control for the facility and is responsible for the collation of infection events and facilitating discussion of data ((link 1.2.3.6). The infection control programme is to be reviewed annually by the IC coordinator.</p> <p>Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. There have been no outbreaks since the previous audit. There were plenty of supplies of personal protective equipment (PPE), gloves, masks, and hand sanitiser.</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 infection control coordinator has attended infection control and prevention education through the DHB in the past year. There is access to infection control expertise within the DHB, aged care consultant, wound nurse specialist, public health, and laboratory. The GP monitors the use of antibiotics and is also available to give advice and support for the IC programme.</p> <p>The recent Covid 19 lock down was well managed, logs have been maintained of staff temperature, and wellness declarations kept. Staff were well updated with new information as it became available. A resource folder has been maintained. There were no admissions during the</p>

		lockdown period. The service continues to maintain contact tracing logs and each visitor must complete a wellness declaration. Visiting remains restricted and is by appointment only. The relatives interviewed during the audit praised the staff and management of Covid 19 and felt well informed and updated regularly.
Standard 3.3: Policies and procedures 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.	FA	The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping, incorporate the principles of infection control. The policies have been developed by an aged care consultant and are reviewed at least annually. There have been recent Covid 19 policies and procedures developed and implemented.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinators are responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Staff complete infection control questionnaires annually with these sighted on staff files reviewed. Hand hygiene competencies are completed during orientation and annually. Resident education is expected to occur as part of providing daily cares. Education was provided to staff around the donning and doffing of personal protective equipment (PPE) and the correct hand washing techniques. Education on the use of hand sanitiser and hand washing was provided to residents.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. Systems in place are appropriate to the size and complexity of the facility. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is expected to be discussed at the combined quality/ staff meetings (link 1.2.3.6). Data and graphs of infection events are available to staff with these displayed in the office. In-service education is provided annually with a good attendance for staff at the last one in 2021.

		There have been no outbreaks since the previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>There is a restraint minimisation and safe practice policy that is applicable to the service. The CNM is the restraint coordinator position with a job description in place. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. Restraint/enabler and challenging behaviour training has been provided annually. Caregivers interviewed could fluently describe the differences between restraint and enablers and procedures around these</p> <p>There are currently no residents using restraint or enablers at Living Waters which has now been restraint free for eight years.</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)
Criterion 1.2.2.1 During a temporary absence a suitably qualified and/or experienced person performs the manager's role.	PA Low	The CNM provides cover for the facility manager if on leave. There is no named replacement in place for the CNM if they are on leave.	Cover for the CNM has not been organised should the CNM be on leave.	Organise a second in charge for the CNM (registered nurse) should they be on leave. 90 days
Criterion 1.2.3.6 Quality improvement data are	PA Low	Quality data is documented against indicators with the report tabled at the quality/staff meeting. The meeting minutes also include tabling of the data. The CNM holds graphs which are displayed in the nurses/staff office. Staff sign if they have not been at the meeting to evidence that they have sighted the data. Quality/staff meeting minutes do not	Quality/staff meeting minutes do not evidence discussion of data with improvements put in place in response to issues	Ensure that the quality/staff meeting minutes

collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		evidence discussion of data although it is tabled in a number of places. The caregivers stated that they did discuss data and gave an example of strategies put in place for one resident who had had a fall recently.	raised.	evidence discussion of data with a corrective action plan documented if required and documentation of resolution of the issues. 180 days
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.	PA Low	The facility manager and CNM stated that they were aware of reporting to HealthCERT using a section 31 form. There has been one notification to HealthCERT of a fractured neck of femur since the last audit. Worksafe was not notified of a serious fall, that involved one staff member in December 2021. The staff member is now back at work and Worksafe was notified by the facility manager on the day of the audit. A section 31 was not completed for HealthCERT and the DHB was not notified however this was followed up by the facility manager on the day of audit.	Worksafe, HealthCERT and the DHB were not notified of a serious incident that occurred for one staff member until the day of audit.	Escalate any serious events as per Worksafe and contractual specifications. 180 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service	PA Moderate	Fifteen incident and accident forms were reviewed (from November 2021 to January 2022 to date). Relatives were notified of the incident or accident in all cases. Staff completed pain and/or post falls assessments when required. Six incident forms were reviewed for residents who had an unwitnessed fall and/or who had hit their head. Four did not have neurological observations taken as per policy (half hourly for two hours then hourly for four hours then reviewed) including observations for one resident who had an unwitnessed fall and had hit their head. Two residents with an unwitnessed fall (including one who had hit their head)	Four of six incident forms for residents with an unwitnessed fall and/or who had hit their head did not have neurological observations taken as per policy.	Ensure that neurological observations are taken as per policy. 60 days

shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		documented neurological observations as per policy.		
Criterion 1.2.7.2 Professional qualifications are validated, including evidence of registration and scope of practice for service providers.	PA Low	There is a recruitment process implemented. Each of the five staff files reviewed had a signed contract in place. Reference checks were not able to be sighted on the files reviewed.	None of the five staff files reviewed had evidence that reference checks had been completed.	Ensure that reference checks are completed prior to appointment of a staff member. 180 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The policy states that staff are to each have an annual performance appraisal. A current performance appraisal was not able to be sighted on one of the four files for staff who had been in the service for more than a year. The sample size was increased to include two more staff files (two cooks) and neither of these had performance appraisals completed.	Three of six staff files reviewed did not have a current annual performance appraisal.	Ensure that each staff member has an annual performance appraisal completed. 180 days
Criterion 1.2.8.1 There is a clearly documented and implemented	PA Moderate	The managers take on three to four days on call each alternating with each other. Staff stated that the one manager was difficult to get hold of and they had to at times had to ring the senior caregiver for advice. The facility manager stated that there had been a shortage of caregivers as caregivers had left towards the end of 2021 (retirement, etc).	i). The on-call staff are not always responding to phone calls. ii). Staff are not always able to be replaced when on	i). Train on-call staff to ensure that they respond to calls in a timely manner

<p>process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>		<p>Interviews with the facility manager and caregivers confirmed that there had been a moderate to high turnover of staff with the service unable to recruit into caregiving positions quickly. Agency staff were not available. On three to four shifts each week on the rosters reviewed (November to January to date), there were indications that staff had not been replaced. Caregivers interviewed said that they tried to complete tasks but at times that was not possible. Caregivers are also responsible for doing laundry and cleaning. The facility manager has recently appointed two caregivers and it is thought that these appointments may help ease the caregiver shortage once they have completed orientation.</p>	<p>leave.</p>	<p>with monitoring of calls and response times to ensure that this occurs.</p> <p>ii). Review caregiver roles and recruit into positions to ensure that there are sufficient staff on duty to manage workload and acuity.</p> <p>90 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There are monthly hot water temperatures of communal showers and handbasins and shared ensuites. Temperatures in communal showers and handbasins were within acceptable limits however the temperatures in shared ensuites were above 45 degrees Celsius.</p>	<p>Hot water temperatures in the shared ensuites had consistently been above 45 degrees Celsius for the last six months. Temperatures ranged between 46-49 degrees Celsius with no evidence of correction actions taken. The risk is considered low as the plumber adjusted the hot water system in the shared ensuites on the day of audit.</p>	<p>Ensure hot water temperatures in resident areas are maintained below 45 degrees Celsius.</p> <p>90 days</p>

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.