

The Ultimate Care Group Limited - Ultimate Care Cambridge Oakdale

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	The Ultimate Care Group Limited
Premises audited:	Ultimate Care Cambridge Oakdale
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 August 2016 End date: 31 August 2016
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:	38



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

Ultimate Care Cambridge Oakdale provides residential care for up to 47 residents who require hospital, rest home, and dementia level care. The facility is operated by The Ultimate Care Group Limited.

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 review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

There are seven areas requiring improvement relating to reporting of quality improvement data to staff; orientation of staff; on-going education and restraint competency assessments; storage of archived documents; resident documentation including assessments; multidisciplinary meetings; the management of weight loss; access to the van for residents who have limited mobility; and aspects of medicine management.

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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The organisation provides services that reflect current accepted good practice. Families and residents interviewed state they are aware of and have access to information around consumer rights including the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Information is provided in the information pack for residents and admission agreements.

There were no residents who identified as Maori at the time of the audit. The service providers report that there are no known barriers to Maori residents accessing the service. Services are planned to provide and promote individual culture, values and beliefs of each resident. Signed consent forms were sighted in all residents’ files reviewed and obtained from residents’ family/whanau, enduring power of attorney (EPOA) or appointed guardians, as required

Complaints management is undertaken according to policy to ensure response timeframes are met. At the time of audit there are no outstanding 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 low risk.
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The Ultimate Care Group Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Ultimate Care Cambridge Oakdale and include a documented scope, direction, goals, values, and a mission statement. Systems are in place for monitoring the service, including regular reporting by the facility manager to head office.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical manager/registered nurse. The clinical manager is responsible for oversight of the clinical service in the facility.

Quality and risk management systems are in place. There is an internal audit programme and an up to date hazard register. Adverse events are documented on accident/incident forms. Internal audits, accident/incident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, staff and health and safety meetings are held on a regular basis. There is reporting on various clinical indicators, quality and risk issues and discussion of any trends identified at the health and safety meetings.

Policies and procedures on human resources management are in place and processes are followed. There are current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and the majority of staff have commenced or completed the New Zealand Qualifications Authority Unit Standards. Individual education records are on staff files.

There is a documented rationale for determining staffing levels and the skill mix in order to provide safe service delivery that is based on best practice. The facility manager and clinical manager are rostered on call after hours. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care.

Consumer information management systems meet the required standards. All resident information is integrated and readily identifiable using relevant and up to date information.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents receive timely, competent, and appropriate services in order to meet their assessed needs. The processes for assessment, planning, provision, evaluation, review, and exit are provided within time frames that safely meet the needs of the resident and meet funder/contractual requirements. The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery.

Residents are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops a care plan specific to the resident. This is developed with the resident, family and existing community supports and health care professionals. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan, as needed. All care plans are evaluated at least six monthly. All residents have 'interRAI' assessments completed and individualised care plans related to this programme.

Residents are reviewed by their GP on admission and assessed thereafter either monthly or three monthly depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

The service provides planned activities programmes in the rest home, hospital and dementia unit. The activities are provided to develop and maintain skills and interests that are meaningful to the resident. Family involvement was demonstrated in the activities.

There are processes in place for a safe medicine management system. Staff responsible for medicine management have been assessed as competent to perform the function for each stage they manage.

The residents were highly satisfied with the meal services. The menu has been reviewed by a dietitian as suitable for the older person living in long term care.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Double and single accommodation is provided in the dementia unit and all bedrooms in the hospital and rest home areas are single. Full ensuites are provided. Adequate numbers of additional bathrooms and toilets are available. Residents' rooms have personal space provided. There are a number of lounges, dining areas and alcoves. External areas for sitting and shading are provided. There are secure external areas in the dementia unit for residents to access.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems, including appropriate monitoring is undertaken to evaluate the effectiveness of these services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There are currently no residents using restraint or enablers. Discussion relating to restraint and enablers is included in the registered nurse meetings.

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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Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in achieving infection reduction. The infection surveillance results are reported to staff and management in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	39	0	5	1	0	0
Criteria	0	86	0	6	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The consumer rights policy contains a list of consumer rights that are in line with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). New residents and families are provided with a copy of the Code on admission and a copy is displayed on the main corridor wall in full view for residents, staff and visitors.</p> <p>On commencement of employment all staff receive induction orientation training regarding residents’ rights and their implementation. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. Staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs.</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</p>	FA	<p>An informed consent policy is in place. Every resident has the choice to receive, refuse and withdraw consent for services. A resident, dependent on their level of cognitive ability, will decide on their own care and treatment unless they indicate that they want representation.</p> <p>The residents’ files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Advance directives are signed by the resident if competent. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in their relative’s care and decision making.</p>

choices and give informed consent.		
<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>All residents receiving care within the facility have appropriate access to independent advice and support, including access to a cultural and spiritual advocate whenever required.</p> <p>Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. The facility has access to an advocate through the district health board.</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>There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident's progress notes and care planning, such as van trips (please refer to criterion 1.3.7) and the attending of different community churches and special events held.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The facility manager (FM) is responsible for complaint management and there are systems in place to manage this process. The FM reported there have not been any complaints since the previous audit and the complaints register confirmed this.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and displayed. The FM advised if there are complaints made, these are reported at the quality and staff meetings. Minutes show complaint management is included as an agenda item on the meeting minute's template.</p> <p>The facility manager reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, the District Health Board, the Accident Compensation Corporation, Police or Coroner since the previous audit.</p>
Standard 1.1.2: Consumer	FA	The policy identifies that a copy of the Code and information about the Nationwide Health and Disability

<p>Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>		<p>Advocacy Service is provided to the resident and family on admission and is evidenced in the admissions agreement.</p> <p>The family/whanau that were interviewed reported that the Code was explained to them on admission. Family/whanau expressed that they were happy with the care at the facility and provided by the staff.</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' files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The families/whanau interviewed reported that the staff are meeting the needs of their relatives and that their relative was treated in a manner that showed regard for the resident's dignity, privacy and independence. At the time of the audit staff were seen to knock on residents' doors and await a response before entering. The use of occupied signs on the bathroom/toilet doors when in use were noted.</p> <p>No concerns in relation to residents' abuse or neglect were mentioned. The family members reported that staff know their relatives well. This was also evidenced at the time of audit with observed interactions.</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 registered nurse and clinical manager reported that there are no barriers to Maori accessing the service. At the time of the audit there were no Maori residents whom affiliated with their Maori culture. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The spiritual, religious and cultural standard operating procedure documents that the admission process includes assessing specific cultural, religious and spiritual beliefs, which includes any cultural nutritional requirements. Staff liaise with family/whanau to ensure cultural or religious visits continue as appropriate.</p> <p>Education on cultural sensitivity and spirituality has been completed. Families and relatives interviewed were happy with the care provided by those staff who also identify with a different culture.</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>Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built and professional boundaries are maintained. No concerns were reported. Staff interviewed stated that they are aware of the importance of maintaining professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice was observed and evidenced in interviews with the facility manager, registered nurses, caregivers and in care planning. Policies and procedures are linked to evidence-based practice. There are regular visits by residents' GP's, links with the mental health services, the hospice, the geriatrician and different DHB nurse specialists and consultants. Care guidelines are utilised as appropriate.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed.</p> <p>The family/whanau interviewed confirmed that they are kept informed of their relative's wellbeing including any incidents adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the residents' progress notes, accident/incident forms and at handover. The July 2016 satisfaction survey stated that relatives were overall satisfied to very satisfied with communication from the facility.</p> <p>All residents and relatives who do not speak English are advised of the availability of an interpreter at the first point of contact with staff. At the time of audit all residents spoke English and two residents had identified English as their second language.</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>	<p>FA</p>	<p>The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided. There are established systems in place which defines the scope, direction and goals of the organisation and UCG facilities, as well as the monitoring and reporting processes against these systems. An organisational flowchart shows the structure and reporting lines within the organisation.</p> <p>A Business Plan and a Quality and Risk Management Plan for Ultimate Care Cambridge Oakdale (Oakdale) includes a mission statement, core values, goals and objectives, quality indicators, quality projects and scope of service. Values, a mission statement and philosophy are displayed. The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring clients to the service.</p>

		<p>The facility manager (FM) provides reports to UCG head office on a weekly and monthly basis via an electronic system. Reports include reporting on quality and risk management issues, occupancy, HR issues, quality improvements and internal audit outcomes, incidents/accidents and clinical indicators.</p> <p>The facility is managed by a facility manager (FM) and a clinical manager (CM). Both managers are registered nurses with current practising certificates. The FM has a number of years' experience in the aged care sector and has been in the current position since 2007. The clinical manager (CM), who is responsible for oversight of the clinical care of residents has been in their role for eight years. The FM reported a new clinical services manager has been employed and they start early in September. The new CSM who is a registered nurse is currently managing a facility in the region and has experience in managing residents who require dementia level care. The current CM will change their role to an RN rostered on shifts. Review of the managers' personal files and interview of the FM and CM indicated the managers undertake education in relevant areas. The regional operations manager for UCG provides support for the facility manager.</p> <p>There is an 'Ultimate Care Group Clinical Advisory Group' (CAG) in place that has four clinical services managers (CSMs) who are responsible for reviewing clinical issues and with non-clinical staff, policies and procedures following feedback from each of the UCG sites. Each of the four CSMs are responsible for liaising with the UCG sites to ensure their participation in the process.</p> <p>Oakdale is certified to provide hospital, rest home and dementia level care. On day one of this audit there were six hospital residents, 24 rest home residents and eight residents requiring dementia level care. One wing with 15 beds has been approved by the Ministry of Health as dual purpose bedrooms providing either hospital or rest home level care.</p> <p>Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</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 facility manager, the clinical manager deputises. When the clinical manager is absent, the facility manager with support from the registered nurses takes responsibility for clinical oversight. The facility manager and the clinical manager confirmed their responsibility and authority for these roles.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management plan guides the quality programme and includes goals and objectives. There was evidence that quality improvement data is collected, collated, and analysed to identify trends and improve service delivery. Corrective action plans are being developed, implemented and reviewed. There is an internal audit programme and completed audits for 2016 were reviewed. The collated resident and family satisfaction survey for 2016 indicated that residents and families are satisfied or very satisfied with the services provided.</p> <p>Quality improvement data is being reported to UCG head office electronically. Minutes for the health and safety monthly meetings evidenced reporting to staff who attend these meetings. Quality, registered nurse, and general staff meetings are also held on a regular basis. The FM reported clinical indicators are discussed at these meetings if there is a reason, such as an increase in the number of falls. Staff were vague when asked at interview and the quality and staff meeting minutes did not evidence reporting back to staff. Graphs and benchmarking data was evidenced in a folder and the FM and staff reported it is available to read. The FM advised they plan to recommence posting the graphs on the notice board in the staff room. Resident meetings are held three monthly and residents confirmed any issues raised are dealt with by the FM.</p> <p>The Ultimate Care Group policies and procedures are fully implemented at Oakdale, and are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. Policies and procedures have been reviewed and are current. Staff confirmed they were required to read and sign off on all the new policies and procedures. Staff also confirmed they provide appropriate guidance for service delivery.</p> <p>A hazard register identified health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual includes relevant policies and procedures and a hazard flow chart to guide staff through the process. An activities coordinator is one of two health and safety representatives and they have attended education relating to the new health and safety legislation. Interview of one the health and safety representatives confirmed their knowledge.</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</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an incident/accident form which are then entered in to the UCG electronic database and held in the residents' files. Data includes summaries and registers of various clinical indicators including, but not limited to, falls, medication errors, unintentional weight loss, skin tears, and behaviour. Documentation reviewed and interviews of staff evidenced appropriate management of adverse events.</p> <p>There is an open disclosure policy. Communication with families following adverse events involving the resident, or any change in the resident's condition was documented in the residents' files. Families</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The FM reported there have been no essential notifications made to the Ministry of Health or any other authority since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are policies and procedures relating to human resources management. Job descriptions outline accountability, responsibilities and authority. Employment agreements, reference checks and police vetting were on staff files.</p> <p>The in-service education programme is the responsibility of the facility manager. Interview of the FM and review of education records evidenced the quarterly study day covering a wide variety of subjects, was last provided in May 2015 and the next one not until August 2016, when 12 staff attended. Staff interviewed confirmed that the study days had only just re-commenced.</p> <p>It was difficult to evidence staff education because there was no overall record of staff attendance and competences. Individual attendance records were not up to date and the FM reported the in-service folder for 2015 had gone with the previous owners of the facility. The FM advised education modules via New Zealand Qualifications Authority Unit Standards had been put on hold, however this is to restart on September including the dementia specific module. Apart from three, all staff working in the dementia unit have commenced or completed the dementia specific modules. Education on medicines has been provided by the pharmacist and competency assessments are current for staff who are responsible for medicine management. There was no evidence of current restraint competency assessments. Some staff have attended external education. The FM advised on line education for staff will be introduced this year.</p> <p>There is a comprehensive orientation/induction programme and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Essential components of the service are covered at orientation. Care staff confirmed they have completed an orientation, however not all staff files reviewed had evidence of an orientation.</p> <p>Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice. Three of the six registered nurses have completed the interRAI education and their competency is current.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice and is calculated electronically. The minimum number of staff is provided during the night shift and consists of one registered nurse and one caregiver in the hospital/rest home areas and one caregiver in the dementia unit. The facility manager and clinical manager are on call after hours. Care staff reported there were adequate staff available and that they were able to complete the work allocated to them. Residents and families interviewed reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover was provided.</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>	PA Low	<p>The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted. Clinical notes were current and integrated with medical and auxiliary staff notes. The current files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident's record reviewed.</p> <p>Archived records are held on site for seven years. No personal or private resident information was observed to be on public display during the days of audit within the facility. The outside storage shed for archived files was observed as unlocked and the archived boxes sitting on the floor of the shed were damp.</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>The resident admission agreement is based on the Aged Care Association agreement. The residents' records reviewed have signed admission agreements by the resident/family or EPOA.</p> <p>Vacancies are updated daily through Eldernet. Staff contact the clinical manager if enquiries are made by potential perspective residents and/or their family members and if outside working hours, staff are guided by facility guidelines.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated</p>	FA	<p>The service uses the DHB's processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident's individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance</p>

<p>transition, exit, discharge, or transfer from services.</p>		<p>directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information.</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>	<p>PA Moderate</p>	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit no residents were self-administering medications.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley individually in the treatment rooms which is locked when not occupied. A locked safe is used for controlled medications and the medicine register was sighted. Medications that require refrigeration are stored in two separate fridges with recorded temperatures documented.</p> <p>The facility has implemented an electronic medication charting and management system. The 14 medicine charts sighted have been reviewed by the GP every three months and this is recorded on the medicine charts. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications, however not all PRN medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.</p> <p>There are documented competencies sighted for designated care staff responsible for medicine management. The registered nurse administering medicines in the rest home at the time of audit was observed to administer to two residents the correct prescribed medication however the medication was evidenced as prescribed for another resident.</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>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. Kitchen staff interviewed had a very good understanding of food safety management and have completed ongoing updated food safety training.</p> <p>There is a six week rotating menu that has been reviewed by a dietitian. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a</p>

		<p>desert and a lighter menu option for dinner also supporting individual residents with different food needs. All main meals are supported by morning and afternoon tea which includes home baking.</p> <p>All meals for the rest home and hospital residents are cooked and served directly from the kitchen and served in the adjacent dining room. A hot plate is used to transport meals to the dementia unit. Residents have the option of trays in their rooms, however all residents are encouraged to have their meals in the dining rooms to encourage appetites and socialisation.</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 clinical manager and registered nurse interviewed reported that the service does not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.</p> <p>If the resident's needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident.</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>The service has implemented the electronic interRAI assessment and specific assessment tools for all residents remain paper based. Assessments are carried out by a registered nurse appropriate to the level of care of the resident and includes falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life, self-medication and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.</p> <p>The residents' files reviewed have assessment information obtained from any prior place of living, services involved, the resident, and where applicable the resident's family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure injury risk assessments.</p> <p>The family/whānau interviewed reported their relative receives 'above and beyond the care required' to meet their relative's needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery</p>	FA	<p>The seven residents' files reviewed have electronic care plans that address the resident's current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sighted in the residents' files. Also evidenced is the</p>

<p>plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual residents they care for.</p> <p>The residents' files reviewed included diversional therapy care plans identifying the resident's individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files showed input from the clinical manager, registered nurse, care and activity staff and medical and allied health services. The registered nurse and caregivers interviewed reported they receive adequate information to assist with the resident's continuity of care. This was also evidenced in the shift handover (verbal and paper) and staff communication book.</p> <p>The family/whanau interviewed reported they were very happy with the quality of care provided at the service.</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>Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.</p> <p>As observed on the days of the audit, the registered nurse and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The registered nurse and caregivers interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's needs.</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>PA Low</p>	<p>The activities programme uses a framework to empower the residents both young and older to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The diversional therapist and activities coordinator adapts activities to meet the needs and preference of choices/cultural preferences of the aged care residents.</p> <p>The facility in the rest home/hospital has a diversional therapist who works Monday – Friday, a total of 40 hours per week and attends education/support group sessions related to his role. The dementia unit is supported by an activities co-ordinator who works Monday - Friday, a total of 40 hours per week. The</p>

		<p>weekly activities plan/calendar sighted is developed based on the resident's individual needs and interests and can be easily adapted and changed depending on the resident's physical ability, interest and reaction at the time. The activities staff advertises the upcoming activities on the calendar by providing this to residents on the notice boards through the facility. Regular activities include daily newspaper reading and exercises, church services, regular visiting entertainment, Ladies and Men's clubs. All public holidays and special events are celebrated. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff promote social interaction by inviting and encouraging all residents to join in activities together in the main lounges.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p> <p>The outside environment provides easy access to outside garden areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.</p> <p>All residents and families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited, however residents interviewed at audit and documentation observed in a recent survey and resident's meetings, stated that they struggle to get in and out of the van when on outings, and some residents are unable to partake in this activity.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or are not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans are sighted for wound care and incidents. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes including evaluations of infections. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover. (Refer criterion 1.3.3.3)</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>There are 11 GPs and associated locums whom combined visit the residents at the facility which also includes an on call component. The RN in discussion with the GP will arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident's file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GP interviewed reported that appropriate referrals to other health and disability services are well managed from the facility.</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>There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets are throughout the facility and accessible for staff. The hazard register is current.</p> <p>There was protective clothing and equipment in the sluice rooms and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff.</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>FA</p>	<p>A current building warrant of fitness is displayed. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs. Families of residents with dementia confirmed the dementia unit has lots of space for their relative to enjoy.</p> <p>There is a proactive and reactive maintenance programme and the buildings, plant and equipment are maintained to a high standard. Maintenance is currently undertaken by a maintenance person. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas with a safe, secure external environment for residents in the dementia unit. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.</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>Bedrooms have full ensuites in the rest home/hospital areas, apart from one. There are adequate numbers of additional bathrooms and toilets throughout the facility. There are appropriate numbers of bathrooms and toilets situated in the dementia unit. Residents and families reported that there are sufficient toilets and they are easy to access.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.</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>There is adequate personal space provided for residents and staff to move around within the bedrooms safely. There are double bedrooms in the dementia unit and families of these residents sharing a room have consented to this via the resident's admission agreement. Residents and families spoke positively about their or their relative's accommodation. Rooms are personalised with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheel chairs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are a number of areas for residents to frequent for activities, dining, relaxing and for privacy. Residents, family and staff confirmed these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. The large lounge has been divided by arranging seating furniture in a way that makes for a number of different areas for residents to access.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning</p>	FA	<p>All laundry is washed on site. Residents and family reported the laundry is managed well and resident's clothes are returned in a timely manner.</p> <p>There are dedicated cleaners on site who have received appropriate education. A cleaner confirmed this. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers.</p>

<p>and laundry services appropriate to the setting in which the service is being provided.</p>		<p>Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.</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>FA</p>	<p>There is an approved fire evacuation plan. There is an evacuation policy on emergency and security situations that covers all service groups at the facility. A fire drill takes place six-monthly. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes. The maintenance person advised emergency lighting is provided by a battery operated system.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs.</p> <p>There are call bells to alert staff. Residents and families reported staff respond promptly to call bells.</p> <p>Contractors must sign in and out of the facility. They are also made aware of any hazards on site. The external doors are locked in the evenings.</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>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by heat pumps in the dementia unit, thermostatically controlled electric heaters in the dual purpose area and ceiling heating in the rest home area. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable.</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</p>	<p>FA</p>	<p>The service has a documented infection control programme. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.</p> <p>The facility manager/registered nurse is the infection control coordinator and is responsibility for following the programme as defined in the infection control manual. Infections are monitored by using standardised definitions to identify infections, surveillance, observing changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at health and safety meetings, however is not discussed at staff meetings (please refer to criterion 1.2.3.6). If there is an</p>

<p>appropriate to the size and scope of the service.</p>		<p>infectious outbreak this is reported to staff, management and where required to the DHB and public health departments.</p> <p>The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover, documented in progress notes and families/next of kin (NOK) are informed. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection, the staff communication book, one to one, at shift handover and in resident's documented progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns are easily accessible to staff. Residents who have infections are encouraged to stay in their rooms if required.</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>	<p>FA</p>	<p>The facility manager/registered nurse has the role of infection prevention and control coordinator. Infection control issues are discussed at staff handover. The facility has the support of a clinical infection control specialist nurse who is available for advice on infection prevention. Advice can also be sought from different external sources including the laboratory diagnostic services and GPs. The infection control coordinator regularly attends infection control education sessions. The registered nurse and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed.</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</p>	<p>FA</p>	<p>An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas, including antibiotic use, methicillin-resistant Staphylococcus aureus (MRSA) screening, bandaging, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices.</p>

implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
<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	The registered nurse and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing technique of staff is reviewed regularly by the registered nurse. Infection control in-service education sessions are held and resident education is provided, as and when appropriate
<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>All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors urinary tract infections, respiratory infections, gastro enteritis, eye, ear, mouth, nose, systemic, skin and soft tissue wounds, pressure injuries. Antibiotic use is also monitored. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. An external contractor benchmarks surveillance data with other facilities.</p> <p>There was an increase in urinary infections in January and February 2016. Four of the six residents are identified as having multiple infections due to their chronic medical history. Care planning and intervention/evaluation was evidenced in progress notes and long term care plans to show how staff were reducing and minimising risk, trends and actions to take to reduce the infection rate for these residents. Two of the six identified residents no longer reside at the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	There are currently no residents using restraint or enablers. The FM reported restraint has not been used since 2014. The restraint/enabler register confirms this. Documentation including policy and procedures are available for staff should restraint be required. The FM is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. Staff were knowledgeable about restraints and enablers.

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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality improvement data is being collected, collated, analysed to identify trends and evaluated. Minutes of the health and safety meetings evidenced this data is being reported back to those staff who attend these meetings and the health and safety representative confirmed this. Minutes of the general staff and quality meetings do not evidence reporting of quality improvement data. The facility manager reported they do discuss any increases in the clinical indicators at the meetings, however, staff were vague when interviewed and reported they used to see graphs posted on the notice board.	Apart from the health and safety meeting minutes, there was no documented evidence that quality improvement data is being reported back to staff.	Provide documented evidence that quality improvement data is reported back to all staff on a regular basis. 180 days
Criterion 1.2.7.4 New service providers receive an	PA Low	Staff interviewed reported they had completed an orientation and could demonstrate what was covered in their orientation. Four of the eight files reviewed did not have evidence of an orientation.	Four of the eight staff files reviewed had no evidence of a	All staff are to have evidence of a completed

orientation/induction programme that covers the essential components of the service provided.			completed orientation.	orientation held on their file. 180 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>	PA Low	<p>There are gaps in the on-going education programme. The programme covers a wide variety of core and other subjects, is delivered via four study days per year and staff are required to attend one of these. The last study day was held in May 2015 and not again until August 2016 when 12 staff attended. There has been other education provided this year including medication, pressure injury, palliative care, hoists, fire safety and continence management. The auditor found it difficult to ascertain exactly what staff had attended education and when, as there is no overall record of staff education and competences held. Individual attendance records are not up to date and the 2015 education folder was not available. Current medicine competencies were sighted for all staff responsible for medicine management. There was no evidence of current competencies for restraint on seven of the eight files reviewed. The one staff member who had a current competency was part of their recent orientation. The FM reported three of the staff working in the dementia unit have not commenced the dementia specific modules and advised this will commence in September. Staff interviewed confirmed there have been gaps with the quarterly study days.</p>	<p>(i) On-going education via study days has not been consistent and as a result there are staff who have not received all ongoing education as required. Because the individual records of staff education are not up to date and the 2015 education folder is no longer available, it was difficult to ascertain what staff had attended education and when.</p> <p>(ii) Three care staff working in the dementia unit have not commenced the specific dementia education. It is acknowledged that they will be starting in September.</p> <p>(iii) There was no evidence of current competency</p>	<p>(i) On-going education is to be provided to all staff on a regular basis.</p> <p>(ii) All care staff who work in the dementia unit are to have completed the dementia unit standards no later than 12 months after their appointment.</p> <p>(iii) All clinical staff are to have a current competency assessment for restraint minimisation and safe practice.</p> <p>180 days</p>

			assessments for restraint on seven of the eight staff files reviewed.	
<p>Criterion 1.2.9.7</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	PA Low	At time of audit current files were observed being kept secure and only accessible to authorised people, however outside storage of archived files was not secure or protected from the environment.	The outside storage shed was observed to be unlocked. The archived boxes with residents' archived files were directly placed on top of each other and damp, as they have direct contact with floor of the storage shed.	<p>Ensure that all consumer information is stored in a secure location, is easily accessible when required, and protected from the risk of damage to documents.</p> <p>180 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</p>	PA Moderate	Medicine charts have each medicine individually prescribed including PRN medications., However not all PRN medications had the reason stated for the use of that medication. There are documented competences sighted for designated care staff responsible for medicine management. The registered nurse was observed administering to two rest home residents the correct prescribed medication, however, the medication administered was evidenced as prescribed for another resident.	Eight of 27 medication charts did not have the reason for use of prescribed PRN medications. A registered nurse was observed giving two rest home residents medication from another resident's prescribed medication bottle.	<p>All staff who are responsible for medicine management are required to meet the requirements of legislation, protocols and guidelines.</p> <p>90 days</p>

order to comply with legislation, protocols, and guidelines.				
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Staff interviewed were able to identify the residents' specific and individual needs. A review of seven residents' files was undertaken and shows that the initial assessment, long term care plans, interRAI social profile and activities assessment, evaluation and review are undertaken within required timeframes. Short term care plans were evidenced for wounds and incidents. Documentation was evidenced in progress notes, however short term care plans were not completed to support infections and weight loss. No multidisciplinary meetings were documented to meet required DHB timeframes and contractual requirements and the organisation's policies and procedures.</p>	<p>In six of the seven files reviewed, no infection identification forms or supporting short term care plans were completed. Four of the seven files reviewed did not evidence multidisciplinary meetings. Four of seven files evidenced residents with weight loss, however no short term care plans or discussions with GP was evident.</p>	<p>Provide evidence that each stage of service provision is undertaken to meet DHB contractual requirements and policy requirements.</p> <p>180 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>Residents stated they enjoy interacting at different events within the community, however residents stated that they are restricted due to their ability to get in and out of the facility van.</p>	<p>Residents and staff discussions/feedback have stated there are residents with reduced/limited mobility who are unable to access the facility van, and thus access to events in the community.</p>	<p>Review the availability of access for all residents when using the facility van to support involvement in community activities.</p> <p>180 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.