

Villages of New Zealand (Pakuranga) Limited - Park Rest Home

Introduction

This report records the results of a Surveillance 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:	Villages of New Zealand (Pakuranga) Limited
Premises audited:	Park Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 September 2017 End date: 29 September 2017
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:	33

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

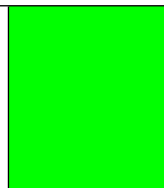
Park Rest Home provides rest home level care for up to 40 residents. The service is one of four facilities owned and operated by Real Living Group which Villages of New Zealand (Pakuranga) Limited is a member of and is privately owned. The care facility is attached to the village complex and is managed by a village manager and an assistant village manager. The care services are overseen by an experienced nurse manager. Only the care facility is covered in this audit.

This surveillance audit was conducted against the Health and Disability Services 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, family members, management and staff. The general practitioner was not available on the day of audit for interview.

This audit has resulted in a continuous improvement in corrective action planning. No areas were identified for improvement. There were no areas for improvement from the previous audit.

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.



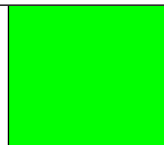
Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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




Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and direction of the organisation. Monitoring of the services provided to the governing body is regular and effective. The village manager has been in the role for seven years, the nurse manager (registered nurse) has held the role for 13 years and the assistant village manager was appointed nine months prior to this audit. Members of the management team are qualified to undertake their roles.

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

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

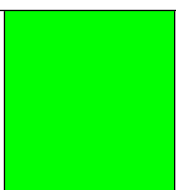
Continuum of service delivery

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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Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty in the facility and are supported by care and allied health staff and a designated general practitioner. On call arrangements for support are in place. Shift handovers and communication books in each service area guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents` records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

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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There is a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support a restraint free environment. No enablers and no restraints were in use at the time of audit. Policy contains comprehensive assessment, approval and monitoring process should they be required. Use of enablers is described in policy as voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by the nurse manager aims to prevent and manage infections. Aged care specific infection surveillance is undertaken, data is analysed, trended, benchmarked and results reported through all level of the organisation. Follow-up action is taken as and when required.

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	16	0	0	0	0	0
Criteria	1	38	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. (Refer comments in criterion 1.2.3.8).</p> <p>The complaints register reviewed showed that no complaints have been received over the past year. Management confirm that if a complaint is received actions taken, through to an agreed resolution. This process is documented to included required follow up. The nurse manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. No section 31 reports have been made to the Ministry of Health.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative`s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents` records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access formal interpreter services through the district health board, although reported this was rarely required. Staff are able to provide interpretation as and when needed, and family members are used when</p>

<p>provide an environment conducive to effective communication.</p>		<p>required.</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 strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports from the nurse manager to the village manager was sighted. The village manager reports any concerns to the board of directors. Information sighted showed monitoring of the care facility performance that is reported at board level includes financial performance, emerging risks and issues.</p> <p>The care service is managed by a registered nurse who holds relevant qualifications and has been in the role for 13 years. They report to the village manager who has been in the role for seven years. The third member of the management team is the assistant village manager who has been in the role for nine months. Responsibilities and accountabilities are defined in a job descriptions and individual employment agreements. Members of the management team confirmed their knowledge of the sector, regulatory and reporting requirements and maintain currency through regular ongoing education related to their roles.</p> <p>The service holds contracts with the Counties Manukau District Health Board for rest home level care including respite care. All 33 residents were receiving services under the Age Related Residential Care contract at the time of audit. Two of the 33 residents were respite care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, and accident and incident reporting.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management, staff and resident meetings as appropriate. The village manager reports to the board at monthly meetings. One or more of the directors visit the facility at least once a week and they are available to staff and residents as requested. Staff reported their involvement in quality and risk management activities through audit activities, review of statistical quality data and corrective action follow up and project planning and implementation. Relevant corrective actions are developed and implemented to address any shortfalls with the outcomes evaluated prior to sign off. This is undertaken to a high level and has gained a continuous improvement rating.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (October 2016) showed that residents are satisfied or very satisfied with services. Any comments made have been followed up by the service.</p>

		<p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are provided by an off-site service and are personalised to Park Rest Home. They are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The village manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The assistant village manager leads the health and safety team as this is their area of expertise.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the nurse manager, village manager and to the board as required.</p> <p>The village manager and nurse manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests, issues based audits and any other notifications (eg, public health) made since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	FA	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period and annually thereafter.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The education and training calendar is available to all staff. Care staff have either completed or commenced a New Zealand</p>

<p>practice and meet the requirements of legislation.</p>		<p>Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. The nurse manager (RN) is trained and competent and maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available from the nurse manager when needed. Residents and family interviewed supported this. Care staff reported there were adequate staff available to complete the work allocated to them. Staff stated that the use of agency nurses had increased. This was discussed with the nurse manager and four weeks of rosters were reviewed. Agency staff are only used to fill a short shift (5pm to 9pm) in the weekend. The facility has advertised for a new staff member for this period. Most vacant shifts are covered by existing staff picking up more hours. The roster review confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</p> <p>A specific staff member is allocated to respond to village call bells. This still ensures the coverage on the care floor meets contractual requirements. From 6pm to 6am there is a guard employed who responds to village call outs.</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>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medication sighted were within current use by dates. Clinical pharmacist input is provided six monthly and on request.</p> <p>The controlled drug register is checked and maintained by the registered nurses. Evidence of weekly and six monthly stock checks and accurate entries were reviewed.</p> <p>The records of temperatures for the medicine fridge is reviewed within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines are met. The required three monthly GP reviews are consistently recorded on the medicine records reviewed.</p>

		<p>There are no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The food service is provided on site by a qualified chef and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and daily menus are displayed at reception and in the two dining rooms. The menu plans have been reviewed by a qualified dietitian. The chef is responsible for all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal and ensures all current legislation obligations are effectively met. The service is working towards the required food service plan to be completed by May 2018.</p> <p>Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The chef and all kitchen staff have completed safe food handling training. A nutritional assessment is undertaken for each individual resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made know to the kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident`s nutritional needs is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided by the staff in each of the two dining rooms sighted in the rest home.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident`s individualised needs was evident in all areas of service provision. The registered nurses interviewed verified that they contact the general practitioner in a timely manner as required, that medical orders are followed, and care is provided. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents` needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as</p>	FA	<p>The activities programme is provided by an activities coordinator with 25 years of experience, 13 at this facility. The activities coordinator is assisted by an activities assistant who implements the programme Monday to Friday and another staff member who spends one hour a day, providing nail and hand care to residents.</p>

<p>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>A full social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly as part of the formal six monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities, individual, group activities and regular events are offered. The programme is divided into three sessions a day. The later session is for residents' who become unsettled in the afternoon. The feedback from staff and families about the programme is positive. Residents and families/whanau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents' interviewed enjoyed the programme and sessions provided. A bus trip is available weekly on a Wednesday afternoon and many residents enjoy this outing into the community.</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>Resident care is evaluated on each shift and is reported in the progress records. If any change is noted, it is reported to the registered nurse.</p> <p>Formal care evaluations, occur every six months in conjunction with the six monthly interRAI reassessments, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the care plan of care. InterRAI assessments are currently fully completed for 21 of 31 residents. Five re-assessments are due in October and two in November 2017. Three re-assessments are currently in draft and being completed by the nurse manager. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and residents being monitored for weight loss. When necessary, and for unresolved problems, long term care plans are updated. Residents and families interviewed provided examples of involvement in evaluation of progress and resulting changes.</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 expiry date 04 March 2018 was publicly displayed.</p>
<p>Standard 3.5:</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin conditions like scabies.</p>

<p>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>		<p>The infection prevention and control coordinator (the nurse manager) reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality and infection prevention and control committee. Data is benchmarked externally by a contracted infection prevention and control service. The annual review for infection prevention and control is completed June 2017. The infection prevention and control surveillance system is adequate for the size and nature of this service. Education is provided to all staff at orientation and is ongoing. The surveillance programme is linked to the quality and risk management programme.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers should they be required. Policy states that enablers are the least restrictive and used voluntarily at the resident's request. The facility operates a restraint free environment. The restraint coordinator would provide support and oversight for enabler and restraint management if required and they demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers. Restraint would only be used as a last resort when all alternatives have been explored. The restraint approval group meeting reflects this and they last met and reviewed all policies and procedures on 27 September 2017. Meeting minutes showed that they continue to promote a restraint free environment.</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.

No data to display

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	CI	<p>The service having fully attained the criterion can in addition clearly demonstrate a review process including analysis and reporting of findings, evidence of action taken based on those findings and improvements to service provision as a result of the review process. Examples sighted included the introduction of a late afternoon activities being introduced to decrease the number of wandering or agitated residents. Staff report this has worked well and the number of incidents reported related to residents wandering or being agitated has lessened. The resident satisfaction survey carried out in October 2016 identified that not all residents (4) were aware of where the complaints forms were kept. This resulted in education being presented at the residents' monthly meetings to ensure everyone was aware of the complaints process and the location of the forms. The residents concerned were then asked if they could locate the complaints forms and they said they could. An internal audit of laundry identified that some items looked 'grey'. The chemical supplier was contacted and worked with the facility to rectify this problem. Consequence audits identify that this problem no longer exists.</p> <p>The nurse manager and village manager discuss all areas of concern and take a generic approach to ensuring all aspects of any issues found are reviewed. This includes a review</p>	<p>All issues that arise from audits, quality data collection, resident satisfaction surveys and complaints are written up on a corrective action form, with actions to be taken and nominated staff to oversee the process. Once the actions are embedded into practice the nurse manager reviews the outcome and signs them off. All corrective actions and outcomes are discussed at management and staff meetings. Residents are informed as appropriate.</p>

		<p>of policy and procedures to ensure they reflect any required changes, review of educational content and presentation to cover any areas that may be included to reflect corrective actions put in place and that current best practice is reflected and understood by all staff.</p> <p>Staff confirmed they are involved in all corrective planning and ensuring actions are embedded into everyday practice. They are informed of any updated policies and procedures as a result of the corrective action and that education presented relevant to any change in practice requirements is verified as best practice. Residents confirmed any concerns they have are acted upon very quickly and that they are informed of the outcome. No negative comments were received during the audit.</p>	
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End of the report.