

Henderson Healthcare Limited - Edmonton Meadows Care Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Henderson Healthcare Limited
Premises audited:	Edmonton Meadows Care Home
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: 19 April 2021 End date: 20 April 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	52

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

Edmonton Meadows provides hospital (geriatric and medical), rest home and dementia level care for up to 60 residents. On the day of audit there were 52 residents. The service is managed by a facility manager (FM) supported by the operations manager/clinical nurse manager (OM/CNM). Both are appropriately qualified and experienced in the aged care sector. The residents and relatives interviewed all spoke positively about the care and support provided.

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

This audit resulted in four identified areas requiring improvement relating to accessibility of policies, linen supplies, medication management, health, and safety.

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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Residents and families are provided with information about the Health and Disability Commissioners Code of Health and Disability Services Consumers Rights' (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residence in a respectful manner.

Open communication between staff, residents and families is promoted and was confirmed to be effective. Interpreting service is available if required. Systems are in place to ensure residents and their families received appropriate information to assist them to make informed choices. Residents' cultural, spiritual, individual values and beliefs are assessed and acknowledged.

Residents who identify as Maori have their needs met in a manner that respects their values and beliefs. There is no evidence of abuse, neglect, or discrimination.

There is an appropriate complaints process that is known to staff, residents, and families. Complaints register and records are maintained. The two complaints that were in the register since the previous audit had the action implemented. Staff, residents and families reported improved staffing levels and moral.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The facility is owned and directed by two private owners. The day-to-day management is undertaken by the FM and OM/CNM who report directly to the owner/directors. The directors monitor the performance closely.

Business and quality management system includes mission statement, philosophy, and long-term plans. The facility is managed by two experienced managers. The managers provide monitoring reports that cover quality data for both residents and staff, results are reported verbally and through the integrated meetings.

The quality and risk management system include collection and analysis of quality improvement data, identifies trends, and is used for improving the service. Staff are involved and feedback is sought from residents and families. Adverse events are documented using the incident and accident process, corrective actions are implemented. Actual and potential risks including health and safety risks are identified and mitigated. Policies and procedures are developed by a third party, they are based on best practice and available to staff via two laptops. Established processes are in place to facilitate client entry to and exit from services.

The appointment, orientation and management of staff are based on good practice. A systematic approach to identifying and delivering ongoing training supports safe service delivery. Annual individual performance appraisals undertaken. Staffing levels and skill mix meet the changing needs and numbers of residents. Resident information is accurately recorded, securely stored and not accessible to unauthorised people.

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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Policies and procedures provide documented guidelines for access to service. Residents are assessed prior to entry to the service to confirm their level of care. The registered nurses are responsible for assessment, development, and evaluation of care plans.

Care plans are individualised and based on the residents' assessed needs and routines. Interventions are appropriate and evaluated in a timely manner.

The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. Activities are conducted for both hospital and rest home residents together.

There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP) and these were current. Staff involved in medication administration are assessed as competent to do so.

The food service provides and caters for residents. Specific dietary likes and dislikes are identified. Residents' nutritional requirements are met. Nutritional snacks are available for residents 24 hours.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of low risk.
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The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are effectively managed. Staff use protective equipment and clothing. Chemicals, and equipment are safely stored. Cleaning and laundry processes are managed by staff and regularly evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practiced. Residents and families reported a timely response to call bells. Security is maintained.

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 the minimisation of restraint. One resident had restraint in use and no enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. An appropriate assessment, and approval process was in place. The need for the use of restraint is regularly reviewed. Staff demonstrated 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 control management system minimises the risk of infection to residents, visitors, and other service providers. The infection control coordinators are responsible for co-ordinating education and training of staff. Infection data is collated monthly, analysed, and reported during staff meetings.

The infection control surveillance and associated activities are appropriate for the size and complexity of the service and is carried out as specified in the infection control programme.

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	47	0	1	2	0	0
Criteria	0	97	0	1	3	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>Edmonton Meadows has documented policies, procedures, and processes to meet its obligations in relation to the code of Health and Disability Services Consumers' Rights (the Code). Training on the code is included in orientation and is delivered annually as per the training schedule, verified in training records. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principle and practices of informed consent. Informed consent policy provides relevant guidance to staff. The admission pack has the required consent forms and residents' files reviewed confirm that consents have been gained appropriately using the organisation's forms. Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is defined and documented in residents' files. All dementia residents had signed EPOA. Residents, including those in the dementia unit were referred to specialists with consent from EPOAs and documents sighted verified that EPOAs consented referrals to specialist services. The general practitioner makes a clinically based decision on resuscitation authorisation. Staff observed during the audit demonstrated consent gaining when providing day to day care. Family members interviewed confirmed management actively involve</p>

		them in decisions that affect their family members.
<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	As part of the preadmission and admission process family are given information about the Code and a pamphlet on the Health and Disability Commission (HDC) advocacy service. Pamphlets on advocacy are available in the entrance foyer. Family members and managers interviewed were aware of the advocacy services, how to access them and the right of the resident to access this service and the right to have support.
<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	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment. Comprehensive activity plans are published, and family invited to attend. Residents in the dementia unit are encouraged if possible, to join in activities that are organised in the main area. Families have unrestricted visiting hours and are encouraged to visit residents and to take them out. Within the facility there is access to several communal areas and outside balcony and garden provide space for families and residents to gather. Family interviewed stated they felt welcome and comfortable when dealing with staff.
<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 complaint policy and associated records meet the requirements of right 10 of the Code. Information on the complaints process is provided in the admission pack. Those interviewed knew how to make a complaint and stated they felt comfortable to do so. Staff interviewed knew there was a complaints process and how to elevate all complaints even verbal. The complaint forms and box are at reception and complaints can be made anonymously if that makes the resident or family more comfortable. All complaints are actioned. The complaints register was viewed and there have only been two complaints since the last audit. One to the police and the HDC (refer to 1.1.3) and one that was to the DHB January 2020. A change in Facility Manager and an increase in staffing levels during 2020 has meant that the issues raised have been addressed. Staff interviewed stated that these changes have made a positive difference and that moral is better than it has ever been, several of these staff members were long serving.</p> <p>The FM is responsible for complaints management and works closely with the OM/CNM, they both stated that concerns are dealt with before they become complaints. All staff were aware of the complaints process. The FM has an open-door policy and we witnessed, residents, family members and staff popping into the office.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Information about the consumers rights legislation, Health and Disability Advocacy Service (Advocacy service) and complaints process is provided in the preadmission and admission packs. The Code is displayed in reception and in yellow wing and there are pamphlets in the entrance with further information. Residents and family members interviewed reported being made aware of the Advocacy Service.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families interviewed confirmed that the residents receive services in a manner that has regard for dignity and privacy, sexuality, spirituality, and choices. Throughout the audit staff were observed maintaining privacy. Residents are supported to maintain their independence with the residents in the dementia unit being able to move freely about the unit and into the secure gardens while those in the other three wings able to go about the facility without restriction. Records sampled confirmed that individual cultural, religious, and social needs, values and beliefs had been identified and included into care plans. Residents that identify as Maori had additional assessment for their cultural needs and these were also included in the care plan.</p> <p>There is an abuse and neglect policy and staff interviewed understood to escalate any incident of abuse or neglect to senior management. The operations manager (OM) charge Nurse (CN) and facility manager (FM) reported that any allegations of abuse or neglect were taken very seriously and immediately followed up. There was one incident reported in May 2020 where a resident accused a health care assistant (HCA) of pushing her to the floor. The Health and Disability Commissioner (HDC) and police investigated and using the footage from closed circuit television (CCTV) established no further action was necessary. All staff interviewed reported that they received in-service education that covers abuse and neglect. Files sampled confirm attendance at education sessions.</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>Staff support residents in the facility who identify as Maori to integrate their cultural values and beliefs. The facility has a cultural policy that includes the principle of the Treaty of Waitangi - this recognises the value of whanau. There is a Kaumatua associated with the facility. Assessments and care plans have additional requirements for residents that identify as Maori to ensure cultural needs are meet and barriers identified and removed. Staff interviewed reported that they attend cultural training, training records support this. On the day of the audit there were three residents that identify as Maori.</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>Residents and their families interviewed verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Residents that attend church services are encouraged to attend local services if they can and monthly services are held in the facility. Residents' personal preferences required interventions and special needs were incorporated into their care plan. Resident meeting minutes reviewed, and satisfaction surveys confirmed individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment, or exploitation and felt safe. Orientation covers identification of personal boundaries; the code of conduct sets out the facilities expectations and every staff member is given a copy. Ongoing training was evidenced in the training records. Policy is available and staff interviewed understood the process if they suspected any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Edmonton Meadows supports good practice through the employment of a third party to keep their documentation current, they encourage and support external education for registered and non-registered staff. Attendance at external education and professional development sessions was evidenced in the staff files reviewed. The OM/CNM and FM provided evidence of having strong external professional support networks, the Waitemata DHB (WDHB) provides the facility with an aged care support facilitator and both OM/CNM and FM sit on the Residential Aged Care Integrated Programme. This forum connects facilities funded by the WDHB and they are currently reviewing the Health Care Assistant (HCA) hand book which is setting consistent care standards across the region.</p> <p>The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed of any changes to their/their relatives' status, including any outcomes from regular or urgent medical reviews and any incidents or accidents. This is supported by residents' records sampled. Open disclosure policy is available, and staff interviewed understood the requirements of the Code.</p> <p>Resident information is freely available and notice boards in communal areas have detailed and pictorial current information for residents and staff.</p> <p>Staff know how to communicate with residents who do not speak English. There were systems in place to communicate including an interpreter policy and contact details. In many instances staff speak more</p>

		<p>than one language and can interpret. Cue cards in different languages have been developed for basic care provision. Care plans include communication requirements. Residents' family members and staff interviewed stated that these work well.</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 business, quality, risk and management plan is reviewed every two years, last reviewed August 2020, it outlines the business' mission statement and philosophy, these are included in the admission pack and the mission statement was posted on the wall in the entrance. The plan documents objectives and goals and is supported by an additional five-year development plan. The business is run by the two directors, an OM/CNM and FM. Monitoring of the business performance is through regular face to face meetings and monthly minute integrated meetings, the directors regularly attend these meetings – information from these meetings is fed to the monthly staff meetings. A sample of meeting minutes were viewed, and staff interviewed confirmed that they attend the staff meetings. Staff meeting minutes available to all staff.</p> <p>The OM/CNM is a registered nurse, has completed level two health and safety qualification, is a diversional therapist, has completed infection control and privacy training with 16 years of experience in residential care. The clinical management of the business is supported by a charge nurse and a clinical coordinator. All three are registered nurses with current practicing certificates which were sighted. All managers have taken on additional appropriate training,</p> <p>A newly appointed facility manager (FM) works with the operation manager/clinical nurse manager to manage the business The FM has 20 years' experience in aged care and has completed the four (4) Quadrant leadership programme, through Wesley institute of learning, and other staff management courses.</p> <p>Responsibilities and accountabilities are documented in job descriptions. The management team meet the requirements of the ARCC contract by attending at least eight (8) hours of performance development annually.</p> <p>Edmonton Meadows is an independently owned service and currently provides rest home, hospital and dementia level care for up to 60 residents. There are 12 dementia beds in one wing and three other wings with 48 rest home /hospital beds. On the day of the audit there were 8 dementia residents, 23 hospital residents, and 21 rest home residents. One (1) hospital resident and four (4) rest home residents were under 65 years on the long-term support chronic health conditions (LTS-CHC) contract. The remaining residents were on an aged residential care contract (ARCC). The home has a respite contract but no respite residents.</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>The day-to-day operation of the service is managed in an efficient and effective manner, the OM/CNM is responsible for the overall running of the business. In the absence of the OM/CNM, the FM continues to run the business and the clinical care is overseen by the charge nurse. The OM/CNM is a registered nurse and InterRAI trained. Both the OM/CNM and the FM are on call 24/7 for the home. Directors can be contacted at any time if they are required. Staff interviewed confirm this occurs.</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 Moderate</p>	<p>The organisation has a business, quality, risk and management plan that outlines quality activities. The quality management system focuses on but is not limited to internal audit, resident satisfaction, incident and accident management, complaints, training, infection control, and is a mixture of quality activities and risk management. Data is compared to the previous month and year. Staff interviewed could describe the quality data collected and how results were fed back through the integrated meeting and staff meetings; meeting minutes sampled support the reporting back of the quality data and are used to manage noncompliance. In the incident and accident system actions are documented, time bound and signed off when completed. In the minutes sampled corrective actions are documented and time bound but not signed off – management were able to show that actions were completed but documentation was limited.</p> <p>Internal audits are comprehensive and cover but are not limited to falls, medication errors, infections, skin tears infections, pressure injuries, challenging behaviour.</p> <p>Resident meetings are held three monthly and there are resident/relative surveys; results reflected respondents were either satisfied or very satisfied.</p> <p>Health and safety are a part of integrated and staff meeting agenda items and managed by the FM and OM/CNM. The operations manager/clinical nurse manager has a level three qualification. The policy states that there is a health and safety committee and that the staff representatives will be elected and trained, staff representatives are listed on a committee team however they are not elected or trained.</p> <p>In 2019 a falls reduction action plan was implemented, and the results have shown that all but one month have seen a reduction in falls. Additional floating staff have been employed to assist with residents during times that were identified as high risk of falls.</p> <p>An improvement is required to ensure that policies and procedures are available and accessible to staff. Health and safety representatives are trained.</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 events using the incident and accident process. A sample of incident/ accident forms reviewed showed these were fully completed, incidents/accidents were investigated, action plans developed, and actions followed up in a timely manner. Data is collated and reported monthly to the integrated and staff meetings. Facility Manager aware of reporting requirements but there had been no notifications since the last audit. As per standard 1.1.3 and 1.1.13 there has been one Health and Disability Commissioner (HDC) complaint which also went to the police and one complaint that went to the District Health Board (DHB). The Health Care Assistant (HCA) apologised to the resident. Both have closed out. There have been no coroner inquests. Post fall assessments were completed for residents' and evidence of this was sighted in files reviewed. Neurological observations for all unwitnessed falls were also completed as per policy requirements and discontinued after a thorough nursing assessment in consultation with the GP.</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>	FA	<p>Human resource policies and procedures are in place and include recruitment, orientation and staff training and development. The recruitment process includes interview and qualification verification and police checks were undertaken.</p> <p>All files sampled had contracts, orientation, job descriptions, training records, annual appraisals, administrative information, and correspondence. Files had performance management documents included. Staff interviewed confirmed that they received orientation and that education opportunities are offered and encouraged.</p> <p>Annual training plan available, training records are in staff files and the topics include but not limited to code of rights, privacy, cultural safety, health and safety, infection control, first aid, restraint and minimisation and safe practice, fire safety/ fire drill, elder abuse, challenging behaviour, skin care, manual handling, elder abuse and neglect. Additional training for hand hygiene and outbreak management was delivered early 2020 and five (5) out of 10 files reviewed had attended this training. All staff working in the dementia unit had ACE dementia training.</p> <p>All registered professionals have current APC's and these were sighted on the days of the audit. Four RNs are interRAI trained and competency assessments were sighted in files sampled. Three other RNs are booked to complete theirs.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	FA	<p>There is a documented and implemented process of determining staffing levels and skill mixes to provide safe service delivery 24 hours a day 7 days a week. Staffing levels are changed to meet changes in resident numbers. The facility manager is on call to manage unexpected staffing changes. There are casual staff available to take additional shifts.</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>Staff reported that recent changes to the staffing level with the addition of floating staff members has meant that they feel there is adequate staff cover, residents and family interviewed confirm staffing levels meet their needs.</p> <p>Six weeks of rosters viewed confirmed adequate staff cover. Every shift has at least an RN on duty in the building and at least one staff member with a current first aid certificate. Only staff who have completed ACE dementia training or equivalent are rostered for duties in the dementia unit. The rosters reviewed, confirmed that at least two care staff are on duty in the dementia wing.</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>	<p>FA</p>	<p>Resident information is kept in paper form. The residents name, date of birth and national index number are used as the unique identifier on all resident's information. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled. Clinical notes were current and integrated with GP and allied health service providers notes. Written records were legible with the name of the person making the entry identifiable.</p> <p>Archived paper records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The entry to service policy includes all the required aspects on the management of enquiries and entry. The admission pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Completed Needs Assessment and Service Coordination (NASC) authorisation forms for the dementia, rest home and hospital level of care residents were sighted. Residents in the dementia unit were admitted with consent from EPOAs and documents sighted verified that EPOAs consented referrals to specialist services. Files sampled evidenced that all residents were assessed by specialists and confirmed current level of care.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding the services provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned</p>	<p>FA</p>	<p>The service has a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to</p>

and coordinated transition, exit, discharge, or transfer from services.		and from the service and there was sufficient evidence in the resident's records to confirm this.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted for pro re nata (PRN) medications, allergies are clearly indicated, and photos were current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors.</p> <p>There was one resident self-administering medications and was assessed as competent. Administration records were maintained, and medicines kept in locked containers. Controlled drug stock takes were conducted. Outcomes of pro re nata (PRN) medicines were documented in the electronic management system.</p> <p>An improvement is required to ensure opened controlled drugs (CDs) injectables are not kept in the cupboard for re-use.</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>There is an approved food plan for the service which expires on 3 July 2021. Meal services are prepared on site and served in the respective dining areas. The menu was reviewed by a dietitian on 27 May 2020. The kitchen staff have current food handling certificates. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. The residents have a nutritional profile developed on admission which identifies dietary requirements, likes, and dislikes. The residents' weight was monitored regularly, and supplements provided to residents with identified weight loss issues. Nutritional snacks are available for residents 24 hours.</p> <p>The kitchen and pantry were observed to be clean, tidy, and stocked. Labels and dates are on all containers and records of temperature monitoring of food, fridges, dishwasher and freezers are maintained. Thermometer calibrations were completed every three months. Regular cleaning is undertaken, and all services comply with current legislation and guidelines. The residents and family/whanau interviewed indicated satisfaction with the food service. All decanted food had records of use by dates recorded on the containers and no expired items were sighted.</p>
Standard 1.3.2: Declining Referral/Entry To Services	FA	The charge nurse (CN) and clinical coordinator (CC) reported that all potential residents who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The person/family is referred to the

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.		referral agency to ensure the person will be admitted to the appropriate service provider.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission, while residents' care plans and interRAI are completed within three weeks, according to policy. Assessments and care plans were detailed and included input from the family/whanau, residents, and other health team members as appropriate. Additional assessments were completed according to the need (e.g., behavioural, nutritional, continence, and skin and pressure risk assessments). Residents in the dementia unit were assessed with input and consent from EPOA. The RNs utilise standardised risk assessment tools on admission. In interviews conducted, family/whanau and residents expressed satisfaction with the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The assessment findings and input from resident and/or family/whanau, informs the care planning and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. Residents in the dementia unit had twenty-four-hour activities care plans in place. Behaviour management plans were implemented as required. Family/whanau and residents confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, gerontology nurses, physiotherapist, occupational therapist, district nurses, dietitian, and GP.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders carried out. The CN reported that the GPs' medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person centred. This was confirmed by the GP during interview. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and in accordance with the residents' needs.

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Planned activities are appropriate to the residents' needs and abilities. Activities are conducted by the activities coordinator and activities assistant with supervision from the OM/CNM who is a qualified diversional therapist. The activities are based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Residents' birthdays are celebrated. A social life history is completed for each resident within two weeks of admission in consultation with the family.</p> <p>The activity programme is formulated by the activities staff. The activities are varied and appropriate for people living with dementia, rest home and hospital level of care. Residents' activities care plans were evaluated every six months and evidence of this was sighted.</p> <p>Twenty-four-hour activity plans reflect residents' preferred activities of choice and are evaluated every six months or as necessary. Activity progress notes and activity attendance checklists are completed daily. The residents were observed participating in a variety of activities on the audit days. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Family members reported overall satisfaction with the level and variety of activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents' long term care plans, interRAI assessments and activity plans were evaluated at least six monthly and updated when there were any changes. Resident care plans were individualised. Relatives, residents, and staff input is sought in all aspects of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term care plans were developed when needed and signed and closed out when the short-term problem has resolved.</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>Residents and family/whānau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent service is indicated or requested, the GP and the nursing team refers to specialist service providers and the DHB with consent from family/whānau. Residents in the dementia unit were referred to specialists with consent from EPOAs and documents sighted verified that EPOAs consented referrals to specialist services. Referrals are followed up on a regular basis by the GP and the nursing team. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital in an ambulance if required.</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>Staff follow documented waste management of waste, infectious or hazardous substances. External companies are contracted to provide waste, cardboard and hazardous waste removal. Pest control is managed externally. Appropriate signage are displayed where necessary. Laundry and kitchen staff have completed training in safe chemical handling. Resident's clothing is labelled by family, staff in the laundry know the residents' personal belongings well. External company manages the chemicals for the washing machine and cleaning chemicals; they provide chemical training and monitoring. Washing machine monitoring reports viewed. Material Safety data sheets were available in areas chemicals are stored and used. Staff interviewed knew where the material data sheets were kept and what to do in the event of a chemical spill.</p> <p>PPE is available in laundry, kitchen, each wing and in the communal bathroom areas. Staff were observed wearing PPE on the days of the audit.</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 expires 15 October 2021 and is displayed publicly. There have been no building modifications since the last audit.</p> <p>The residence is purpose built and comprises of large communal areas and four wings. Planned and reactive maintenance occurs and there is a maintenance person employed. Maintenance records confirmed the process used for maintenance. Staff interviewed stated that there is sufficient equipment, this was observed being used during the audit days.</p> <p>Appropriate systems are in place to ensure the residents' physical environment is fit for purpose and maintained. Testing and tagging of electrical equipment and calibration of biomedical equipment were all current, records reviewed confirmed this. Hot water checks are undertaken monthly, and temperature must be under 45 degrees Celsius with evidence of remedial action taken when temperature exceeds the stipulated level. External areas are safely maintained and are appropriate for the resident groups.</p> <p>Staff and residents confirmed they know the process to follow if any repairs and maintenance is required. The facility has a van for outings and transporting residents, it has a current warrant of fitness that expires 7 August 2021 and a fist aid kit was in place.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing</p>	<p>FA</p>	<p>There are adequate number of accessible bathrooms and toilet facilities throughout the facility, including designated staff and visitors' toilets. Two of the rest/home hospital wings had six rooms each with an ensuite, the white wing and the dementia wing do not have ensuite bathrooms. All wings have a large communal bathroom with two toilets, a shower, and a bath. There is a shower roster, so residents'</p>

<p>facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>privacy is maintained.</p> <p>Bathrooms have call bells, handrails, signage and are well lit, heated, and ventilated. While the building is aging, the bathrooms remain in good condition.</p> <p>Appropriately secured handrails are provided in the toilet and shower area and other equipment is available to promote residence 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>	<p>FA</p>	<p>All residences have single rooms that are large enough for them to have their own belongings and be able to move around in, each room has a call bell, and these are checked monthly, records viewed. All residents interviewed stated their call bells are in working order and are answered in a timely manner.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Each wing leads into large communal areas that are connected, but separated, there is ample room for the residents. There is a large dining room and covered in outdoor deck with ample furniture. Residents can find quiet spaces for privacy, if required. Activities take place in both the large lounge area and in the second lounge area which has a pool table. Furniture is appropriate to the residence needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>PA Low</p>	<p>The laundry is undertaken on site in a dedicated laundry. Laundry staff interviewed understood the laundry processes. Laundry has clearly marked clean and dirty lanes and linen receptacles. Residents and family interviewed stated the laundry is managed well and clothes are returned in a timely manner.</p> <p>Chemicals for both the laundry and cleaning are supplied by an external company. The washing machine has electronic chemical insertion for each wash. The machine is monitored by the external company and monthly reports provided to management. These reports were reviewed. Laundry and cleaning staff interviewed knew where the material safety data sheets were and could explain basic first aid for chemicals they use. Training provided by the external company and training records were sighted in files sampled.</p> <p>Chemicals and cleaning trolleys were locked away when not used. Chemicals were in appropriately labelled containers. Laundry and cleaning processes are monitored by internal audits and results were</p>

		<p>sighted during audit.</p> <p>The building is aging the facility was clean, tidy and free of clutter.</p> <p>An improvement is required to ensure there is adequate stock of sheets and pillowcases.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Polices and guidelines for emergency planning, preparation and response are displayed and known to staff. Emergency planning considers the unique needs of people with dementia.</p> <p>The current fire and evacuation scheme was approved by the NZ fire service in September 2000. A trial evacuation takes place six-monthly with a copy sent to the New Zealand fire service, the most recent being 1 November 2020. Records sighted show that trial evacuations have occurred within the require time frames since the previous audit. The orientation process covers fire and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>The onsite fire suppression systems are checked monthly by a qualified company, records viewed. Emergency lighting is available and checked regularly last checked September 2020.</p> <p>Adequate supplies are kept for use in a civil defence emergency, including food, water (tanks and container), continence products, blankets and other supplies that meet the requirements for 60 residents.</p> <p>The call bell system is checked monthly, and records were sighted. This was observed to be functioning on the audit days. Residents and family report staff response promptly to call bells.</p> <p>Edmonton Meadows has appropriate security processes in place. The external doors are alarmed, main corridors have CCTV (with adequate signage) staff on both afternoon and night shift do a full round and check all doors and window are shut and locked – they sign once this is completed. There have been no security incidents reported.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. All rooms have natural light, opening external windows and doors. Heating is provided by electrical heat pumps with individual controls in each room. The facility was well heated and ventilated throughout the audit. Residents and families reported that the facility is maintained at a comfortable temperature.</p> <p>The organisation has a smoke free policy for staff and a designated smoking area for residents. No residents were seen smoking during the audit.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>Edmonton Meadows provides an environment that minimises the risk of infection to residents, staff, and visitors by implementing an appropriate infection prevention and control programme. The charge nurse and clinical coordinator core share the role of the infection control coordinator (ICC) supported by the OM/CNM. The ICC has access to external specialist advice from a GP and DHB infection control specialists when required. A documented role description for the ICCs including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually and is incorporated in the monthly staff and integrated meetings. A review of the education programme is conducted. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.</p> <p>There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for residents, staff, and visitors to use. There have been no outbreaks documented and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control programme. Regular updates and information on COVID-19 are provided to staff, families, and residents. Restricted visiting times are put in place in response to national COVID-19 pandemic alert levels.</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 ICCs are responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at monthly staff and integrated meetings. The ICCs have access to all relevant resident data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, and the attending GP.</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>The organisation has documented policies and procedures in place that reflect current best practice. Policies and procedures are accessible and available for staff. These were current and have been updated to include COVID-19 requirements. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. Staff demonstrated knowledge on the requirements of standard precautions and have access to policies and procedures.</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	Staff education on infection prevention and control is conducted by the ICCs and other specialist consultants. All staff attend an annual infection prevention and control training. A record of attendance is maintained and was sighted. The training information pack is detailed and meets best practice and guidelines, including COVID-19 requirements. External contact resources include GP, laboratories, and local district health boards. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored, and reviewed monthly. Monthly reports are completed and sent to the FM and OM/CNM respectively. The ICCs reported that an infection control record is completed when a resident has an infection. Internal benchmarking of infection is completed. Staff interviewed reported that they are informed of infections at handovers, monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The assessment, approval, monitoring and review process is the same for both restraints and enablers. An updated restraint register was sighted, and staff interviewed understood the difference between restraint and enablers. Risk minimisation was documented in the care plans of the residents and restraint was evaluated regularly. Approved equipment which can be used as a restraint includes bedrails and lap belts. At the time of the audit there was one resident on restraint and none using enablers. The family and residents were informed about the restraint process and risks involved.</p> <p>All staff have completed a restraint minimisation competency during orientation. This includes definitions, types of restraint, consent processes, monitoring requirements, de-escalation techniques, risks, reporting requirements, evaluation and review process.</p>
Standard 2.2.1: Restraint approval and processes	FA	The charge nurse is the designated restraint coordinator and is responsible for education of staff ensuring the restraint process is followed according to restraint minimisation and safe practice

<p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>		<p>standards. The roles and responsibilities of the restraint coordinator are clearly defined and there are clear lines of accountability for restraint use. The approval process is in place and includes the CN, GP and a family representative. The required approvals were sighted in records of restraint. Restraint use is discussed in integrated and staff meetings respectively.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator undertakes the initial assessment with input from the resident's family/whānau/EPOA and GP. The restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of resident who was using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members including the use of sensor mats and low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected.</p> <p>A restraint register was maintained, updated every month and reviewed at each integrated and staff meeting. The register was reviewed and contained the resident currently using a restraint and enough information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use. Staff were trained in restraint minimisation on 19 January 2021 and managing challenging behaviour on 18 March 2021.</p>
<p>Standard 2.2.4: Evaluation</p>	<p>FA</p>	<p>Regular reviews are conducted on the resident with a restraint and this was evident in the records sampled. The GP confirmed involvement in the restraint review process. Reviews included discussions</p>

<p>Services evaluate all episodes of restraint.</p>		<p>on alternative options, care plans, least amount of time and impact on the resident, adequate support, sufficient monitoring and any change required. Staff and family/whanau confirmed involvement in restraint use evaluations. The evaluation forms included the effectiveness of the restraint and the risk management plans were documentation in the long-term care plans. Evaluation time frames are determined by the risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The service has demonstrated monitoring and quality review on the use of restraint. An internal audit was conducted regarding restraint use on 22 January 2021. This included a review of all restraint use and associated processes, including the policies and procedures. This resulted in a corrective action regarding care plan documentation. The corrective action and implementation was discussed at the monthly staff and integrated meetings.</p> <p>Restraint updates are routinely included in the monthly staff and integrated meetings. Meeting minutes confirmed discussions on restraint are being conducted and included review of restraint use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Moderate	<p>The development of the documents and the management of document control is outsourced to a third party. The policies and procedures have recently been transferred from paper to electronic management. The OM/CNM reported that policies and procedures are available on laptops in the nurse’s room and in yellow wing office, staff can access them, however two (2) out of 5 staff interviewed did not know that the laptop was where the polices were kept and how to access them. Accessibility and knowledge of policies and procedures was limited.</p>	<p>2 out of 5 staff interviewed did not know about the polices and how to access them or where to find them.</p>	<p>Ensure policies and procedures are readily accessible and available to staff when required.</p> <p>60 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their</p>	PA Moderate	<p>Hazards are identified, managed, and documented on a hazard register. Hazard register is updated as required and reviewed annually; changes communicated via staff meetings. Staff interviewed articulated the hazard management process and</p>	<p>(i)Health and safety staff representative are not</p>	<p>(i)Hold health and safety representative elections and</p>

<p>family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>		<p>that all health and safety issues are covered in meetings. Contractors and new staff are orientated to health and safety systems. However, the documentation refers to the 1994 and 2002 legislation. Health and safety staff representative are not elected or trained.</p>	<p>elected or trained.</p> <p>(ii) Health and safety policy refers to the 1994 and 2002 legislation.</p>	<p>provide training to staff representative as per the legislation.</p> <p>(ii) Provide evidence of an updated policy that refers to current legislation Health and Safety at Work Act (2015).</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from hospital or any external appointments. The RNs check medicines against the prescription, and these were updated on the pharmacy delivery forms. The GP completes three monthly reviews. There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Monitoring of medication room temperature was maintained. The RN and HCA were observed administering medications safely and correctly. Medications were stored in a safe and secure way in the trollies and locked storeroom. Medication competencies were completed annually for all staff administering medication. The CN and CC reported that medication related audits were conducted.</p>	<p>Left over medicines of injectables CDs (oxynorm) were not being disposed of immediately but kept for reuse.</p>	<p>Ensure appropriate disposal of left-over CDs to comply with current legislation, protocols and guidelines.</p> <p>30 days</p>

		Proper disposal of opened ampoules of CDs to meet current medication legislative requirements is required.		
<p>Criterion 1.4.6.2</p> <p>The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	PA Low	<p>During the review of the laundry, it was identified that there was a shortage of linen in particular sheets and pillowcases. Management explained that this was an internal process failure and stock had been used and not replaced. Sheets and pillowcases were limited in supply, none were in store cupboards checked.</p>	<p>Inadequate linen particularly sheets and pillowcases to meet residents' needs.</p>	<p>Ensure adequate linen is supplied to meet residents' needs.</p> <p>60 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.