

Belmont Hospital Limited - Eversleigh Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Belmont Hospital Limited

Premises audited: Eversleigh Hospital

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 31 May 2021 End date: 1 June 2021

Proposed changes to current services (if any): Sale of service and change of ownership based on outcome of this report with the sale date planned for 5 June 2021

Total beds occupied across all premises included in the audit on the first day of the audit: 27



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.

General overview of the audit

Eversleigh Hospital provides rest home and hospital level care for up to 38 residents. At the time of the audit there were 27 residents in total. The residents, relatives and general practitioner commented positively on the care and services provided at Eversleigh Hospital.

The service is managed by a facility manager who has been in the role at Eversleigh Hospital for four years with over 20 years' experience in aged care.

This provisional audit was conducted against the relevant Health and Disability services standards and the contract with the district health board. The audit process included a review of policies and procedures and other documentation; the review of residents and staff files; observations and interviews with residents, the chief operating officer, staff; an interview with the general practitioner; and an interview with the potential purchaser.

The prospective owner of the service owns three other care facilities and has extensive knowledge of the Aged Related Care contract. The prospective owner will continue to implement existing systems with a transition plan in place should the sale go ahead on confirmation of this audit.

There were 11 shortfalls identified at this audit around the business plan and policies, the quality programme, completion of documentation in resident records in a timely manner, documentation of neurological observations, the activities programme, to documentation of administration of medication, repairs internally and to a safe external environment.

Consumer rights

The service provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy, and informed consent. Information about the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and related services is readily available to residents and families. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with community.

Organisational management

There is a quality and risk management programme in place. Incidents and accidents are reported. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Residents and families are surveyed annually. Health and safety policies, systems and processes are documented.

Appropriate employment processes are adhered to and all employees have an annual staff performance appraisal completed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. There is a

documented annual in-service education schedule. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six- monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent health care assistants responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated.

Safe and appropriate environment

The building holds a current warrant of fitness. Fixtures, fittings, and internal flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances. Electrical equipment has been tested and tagged. All medical equipment and all hoists have

been serviced and calibrated. Residents can access communal areas. Cleaning and laundry services are monitored through the internal auditing system.

Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place. On the day of audit there were three residents using restraints and two residents with an enabler. One resident record where restraint was being used and two resident records where an enabler was used were reviewed and included completed consent forms, assessment of restraint including identification of risks and a care plan with interventions documented. Staff receive training in restraint minimisation and challenging behaviour management at least annually.

Infection prevention and control

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (RN) is responsible for coordinating education and training for staff. The infection control officer has completed annual training through an online provider in addition to Covid education provided by the local DHB. There is a suite of infection control policies and guidelines to support practice. The infection control officer uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	43	0	3	4	0	0
Criteria	0	90	0	5	6	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Discussions with care staff, including four caregivers, a registered nurse (RN), one cook, maintenance, cleaner, laundry and one activities coordinator confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Seven residents (two rest home – one of whom was a resident using respite services, and five hospital) and two relatives (all hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.</p> <p>Staff have received training around the Code in 2020 and 2021 with all staff attending.</p> <p>The potential purchaser of the company was interviewed and was able to list the rights as per the Code with examples given of application to practice.</p>
<p>Standard 1.1.10: Informed Consent</p>	FA	<p>Informed consent processes are discussed with residents and families</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>		<p>on admission. Written general consents reviewed in six resident files (two rest home and four hospital) were signed by the resident or their enduring power of attorney (EPOA).</p> <p>Advanced directives and/or resuscitation status are signed for separately by the competent resident. Copies of EPOA are kept on the residents file where required and activated where necessary. Caregivers and the registered nurse (RN) interviewed, confirmed verbal consent is obtained when delivering care. Discussion with family members stated that the service actively involves them in decisions that affect their relative's lives.</p> <p>Six resident files sampled have signed admission agreements including a short-term agreement for a respite resident.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code on entry to the service and this includes information around advocacy services. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.</p> <p>The potential purchaser was able to give a description of advocacy services and how they would be able to support residents if required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, clubs, and interest groups in the community. Residents confirmed the staff help them access community groups.</p> <p>The managers and staff actively engaged with family on behalf of residents during the Covid lockdown period and they also support residents to engage with their family members through email. During</p>

		Covid-19, there were Facebook updates as information changed.
<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>There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The facility manager leads the investigation of concerns/complaints. Complaints forms are visible for relatives/residents and staff were able to articulate where these were kept. A complaints procedure is provided to residents within the information pack at entry. The service has responded appropriately to two complaints raised in 2020 and four in 2021. The complaints were addressed in a timely manner as per policy and the complainants were satisfied with the outcomes.</p> <p>The complaints register is up to date. Management operate an “open door” policy.</p> <p>The potential purchaser has knowledge of managing complaints in other aged care facilities owned by them. They were able to describe processes including timeframes for responding to complaints.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The service provides information to residents that includes the Code, complaints, and advocacy. Information is given to the resident, family, or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Six monthly resident/relative meetings provide the opportunity to raise concerns. An annual resident/relative satisfaction survey is completed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with the requirements of the Privacy Act 2020. The residents’ personal belongings are used to decorate their rooms. There is one double room with all others identified as being for a single occupant. The double room is not currently occupied, and the facility manager stated that this is used for couples only. Curtains are able to be put up if residents chose to share and if they did, each would sign a consent form agreeing to share.</p>

		<p>Adequate space is available for discussions of a private nature.</p> <p>Care staff interviewed reported that they knock on bedroom doors prior to entering rooms, and ensure doors are shut when cares are being given. Staff were observed knocking on doors before entering the resident rooms during the audit. All residents interviewed confirmed that their privacy is being respected.</p> <p>All residents' private information is kept in a secure area when not in use.</p> <p>Guidelines on abuse and neglect are documented in policy. Staff have received training on abuse and neglect prevention in 2020. The facility manager and staff interviewed stated that there is no evidence of any abuse or neglect by staff and there were no incidents since the last audit around abuse or neglect. Residents interviewed stated that there was no evidence of abuse or neglect.</p> <p>The potential purchaser was interviewed and understands responsibilities if abuse or neglect is identified. The interview with the potential purchaser confirmed that they had knowledge of processes to manage any potential incidents and understood how to escalate any issues.</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>	<p>FA</p>	<p>Eversleigh Hospital has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were no residents who identified as Māori. Māori consultation is available through the local kaumātua. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori. Staff have all had cultural training in the past year.</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</p>	<p>FA</p>	<p>The resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Care plans sampled included the residents' values, spiritual and cultural beliefs. Six monthly reviews occur to assess if the</p>

<p>respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>resident's needs are being met. Discussion with family and residents confirmed values and beliefs are considered. Residents are supported to attend church services of their choice and there are weekly spiritual services for residents.</p> <p>There are two residents who speak English as a second language. One resident will speak English when prompted and there are translation cards for the other resident with family who also can interpret. The facility manager and staff stated that they would use interpreting services through the district health board as required and staff themselves speak different languages.</p> <p>The potential purchaser stated that they have links with the district health board already and will access these when required.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff described implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment, and exploitation. Training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed stated that they were aware of the policies and were active in identifying any issues that relate to the policy.</p> <p>Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the staff files sampled. Staff comply with confidentiality and the code of conduct. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p> <p>Residents and family interviewed confirmed that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register since the last audit relating to any form of discrimination or exploitation.</p> <p>The potential purchaser was able to describe signs and symptoms of abuse and neglect along with clear processes to escalate if ever identified.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The facility manager described being committed to providing services with quality improvement in mind. Policies and procedures are in place to guide service delivery.</p> <p>All residents and family member interviewed were positive about the care provided. The general practitioner was satisfied with the care provided and stated that any issues were escalated in a timely manner.</p> <p>Staff have a sound understanding of principles of aged care and stated that they feel supported by the facility manager. Monthly meetings enhance communication between the staff and provide consistency of care.</p> <p>The potential purchaser stated that they would continue using all existing systems in the service as these had been tried and proved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures.</p> <p>Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident.</p> <p>Twenty incidents/accident forms were reviewed for 2021. The forms included a section to record family notification. The incident/accident forms indicated family were informed or if family did not wish to be informed. Family members interviewed confirmed they are notified of any changes in their family member's health status.</p> <p>Resident meetings encourage open discussion around the services provided (meeting minutes sighted).</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The nurse manager stated that information is given to a potential resident and family by the need's assessment service as well as the service at the time of enquiry into the service and when entering the service.</p> <p>There is access to an interpreter service as required.</p>

		<p>During the lockdown period of the Covid pandemic, there was evidence that the service had connected with residents and family through email and phone. Residents were kept well informed. The potential purchaser described management of Covid-19 in other facilities with these matching Ministry of Health and district health board instructions.</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>PA Low</p>	<p>Eversleigh is owned and operated by Golden Concepts E Limited who purchased the service in May 2015. The service provides rest home and hospital level care for up to 38 residents, which includes three beds in serviced apartments. At the time of the audit there were 27 residents in total: five rest home level including one using respite care services, and 22 hospital level. The occupancy includes three residents in the serviced apartments (one requiring hospital level of care and two requiring rest home level of care). All beds are dual purpose beds. All residents were under the age-related residential care (ARRC) agreement. There are no residents under a medical contract.</p> <p>The service has a business plan, which is expected to be reviewed regularly. The service has quality goals for 2021. The service is managed by a facility manager who has been at Eversleigh Hospital for four years and has worked in the aged care sector in clinical and facility management roles for over 20 years. The facility manager is supported by a senior registered nurse and an administrator.</p> <p>The facility manager has completed at least eight hours of professional development.</p> <p>The potential purchaser is a registered nurse with over 10 years' experience in aged care including management of facilities. They have completed at least eight hours of professional development related to the role.</p> <p>The potential purchaser part owns three other facilities (two rest homes and a dementia unit). The proposed sale of the business is set for 5 June 2021 or the date of confirmation through the audit. The transition plan developed by the prospective owner confirms that they will be on site for 20 working days to work with the existing owner and facility manager so that the business has stability during the handover period. The potential purchaser will be facility manager following a successful</p>

		sale.
<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>	FA	<p>During a temporary absence, the senior RN covers the facility manager's role with the support from the care staff. If the sale progresses, the potential manager will take over the facility manager role with continued support and cover when required from the senior registered nurse.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Moderate	<p>Golden Concepts E Limited has a quality and risk management programme in place. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001 noting that policies are expected to be reviewed at least every three years. Not all policies have been reviewed in a timely manner. Staff confirmed they are made aware of any new/reviewed policies.</p> <p>There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Data related to incidents and accidents is collated. Corrective actions are documented if issues are identified in audit reports with these signed off by the facility manager showing resolution of issues in a timely manner. There is a monthly staff/quality/risk/safety meeting that includes tabling of data. The minutes for 2021 do not evidence discussion of issues or tabling of correct data as per the data collation forms. There is a six-monthly resident/relative meeting.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The facility manager is responsible for health and safety education, internal audits, and accident/incident investigation. There is a current hazard register in place and was last reviewed in 2020. Staff confirmed they are kept informed around health and safety matters at meetings. Falls management strategies include individualised strategies, equipment in use for residents with high falls and hourly observation of residents who</p>

		<p>might fall. Staff were observed to support residents who had difficulty walking or mobilising well on the days of audit.</p> <p>An annual resident and relative satisfaction survey was completed in November 2020 with an overall satisfaction rate of 78.4%. A corrective action plan was not documented. Staff were aware of results with this tabled in the December 2020 staff/quality/risk/safety meeting. Residents were also informed of the results.</p> <p>There are no planned changes to the quality, risk management or health and safety systems should the sale be realised unless issues and corrective actions are raised in this audit report.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's quality and risk programme and expected to be used for quality improvement (link 1.2.3.6). The facility manager investigates accidents and near misses and analysis of incident trends occurs.</p> <p>Twenty resident related incident reports were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a RN. Neurological observation forms were not always fully completed as per policy for residents with unwitnessed falls or with a potential head injury (link 1.3.6.1).</p> <p>Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications completed 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 practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are human resource management policies in place. A copy of practising certificates is kept for all health professionals who are in or visit the facility including the dietitian, podiatrist, doctor, pharmacists. The recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications,</p>

		<p>experience, and veracity and these were sighted in all staff records reviewed (six including the facility manager, two RNs, cook, activities coordinator and one caregiver). Staff files reviewed evidenced that reference checks were completed before employment is offered and all had relevant documentation relating to employment.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. New staff interviewed described a buddy system and orientation to the service and policies. There is an annual training plan that is implemented. The service also provides toolbox talks at regular intervals on topical issues and/or resident needs. The facility manager and RNs are able to attend external training, including sessions provided by the local DHB. Four of the six RNs have completed interRAI training. Two have completed level two training, six with level three training and three currently in training, and one with level four training. Training for staff around Covid-19 has been provided in 2020 and 2021 including use of personal protective equipment (PPE) and use of isolation if required.</p> <p>There are no planned changes to the orientation and training programme or HR management if purchased.</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 policy in place that determines staffing levels and skill mixes for safe service delivery. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts. The roster is flexible to adapt to changes in resident need and/or numbers including ensuring residents in the three serviced apartments are supported.</p> <p>The facility manager (RN) and the senior RN are on duty during the day from Monday to Friday. An RN is available on call weekends and after hours and can contact the facility manager as required for any clinical concerns. There is a RN on duty 24 hours a day/seven days a week. Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the facility manager and senior RN who respond quickly to after-hours calls.</p> <p>There is a current occupancy of 27 residents inclusive of residents in serviced apartments. The service is divided into two wings. In wing A,</p>

		<p>there are 17 of 17 residents (three rest home and 12 hospital). In wing B (21 beds), which includes the three serviced apartments, there are 10 residents requiring hospital level of care (including one in a serviced apartment) and two residents requiring rest home level of care (both in the service apartments. The service is staffed overall with the following on duty (noting that staff is allocated to according to numbers and acuity of residents): two HCA from 7 am to 3 pm, two from 7 am to 1 pm, and one from 8 am to 12 pm on the morning shift; one HCA 3 pm to 11 pm, one 3 pm to 10 pm, and two from 4 pm to 8 pm on the afternoon shift; two HCA on the night shift from 11 pm to 7 am.</p> <p>There are no planned changes to staffing if purchased.</p>
<p>Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office or my password protection if electronic. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.</p> <p>Entries were legible, dated and signed by the relevant HCA or registered nurse, including designation.</p> <p>There are no planned changes to the record management system should the proposed sale go ahead.</p>
<p>Standard 1.3.1: Entry To Services 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>There is an implemented admission policy and procedures to safely guide service provision and entry to the service. All residents have a needs assessment completed prior to entry that identifies the level of care required. The facility manager screens all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident. The service has an information pack available for residents/families/whānau at entry. The admission information pack outlines access, assessment, and the entry screening process. The service operates twenty-four hours a day, seven days a week.</p>

		<p>Comprehensive information about the service is made available to referrers, potential residents, and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement. The six admission agreements reviewed meet contractual requirements and were signed and dated. Exclusions from the service are included in the admission agreement.</p> <p>Family members and residents interviewed stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the facility manager is available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission in to the facility.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were two residents self-medicating on the day of audit, one of whom had been assessed as competent to self-administer by the RN and GP. The residents' rooms were visited and the resident's confirmed that their rooms had no secure storage for the medications used. Legal requirements had not been met. There are standing orders in use which are comprehensively documented, including indications for use, frequency, and maximum doses. These are reviewed three-monthly by the GP. There are no vaccines stored on site.</p> <p>The facility uses an electronic medication management and robotic pack</p>

		<p>system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and medication competent caregivers administer medications, have up-to-date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily and are within the required ranges. Eye drops viewed in both medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Twelve medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The head chef oversees the procurement of the food and management of the kitchen. All meals are cooked on site. The kitchen was observed to be clean and well organised, and a current approved food control plan was in evidence, expiring November 2021. Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu is approved by an external dietitian.</p> <p>Residents and families interviewed expressed satisfaction with the meals. Additional snacks are available at all times.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service records the reason for declining service entry to potential residents should this occur and communicates this to the consumer and where appropriate their family/whānau member of choice. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered for long-term residents during admission in consultation with the resident and their relative where appropriate, however the service does not follow this process for respite residents (link 1.3.3.3). InterRAI assessments had been completed for all long-term residents' files reviewed excluding one short-term respite resident. Initial interRAI assessments and reviews are evident for five of six resident files sampled.</p> <p>Long-term resident files reviewed identified that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the long-term resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident-centred. Interventions documented support needs and provide detail to guide care. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals, including the dietitian, wound care specialist and PEG nurse specialist. The care staff interviewed advised that the care plans were easy to follow. Integration of records and monitoring documents are well managed.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the standard of nursing and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Nutrition has been considered, with fluid and fluid monitoring, regular weight monitoring and weight management implemented where weight loss was noted. The kitchen staff were aware of resident's dietary requirements and these could be seen documented and were easily accessible for staff in the kitchen. Interventions are documented in order to guide the care staff. Care staff interviewed, stated that they found these very helpful.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included two chronic wounds, two skin tears, three grade 2 pressure injuries (facility acquired) and two grade 1 facility acquired pressure injuries. There was evidence of wound nurse specialist involvement in chronic wounds management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds and neurological observations.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>There is one activity coordinator covering Monday to Friday who plans and leads all activities. The coordinator prepares activity resources for weekends, with resources labelled and easily identifiable for caregivers and families to utilise as required. Residents were observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities which are varied</p>

		<p>according to resident preference and need. These include (but are not limited to) exercises, cooking, crafts, games, quizzes, entertainers, pet therapy, art, and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as nail care, reminiscence sessions and hand massage are offered.</p> <p>There are fortnightly outings, and the service utilises a community-based wheelchair accessible minibus as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as cultural dance groups, churches, and children's groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were very positive about the activity programme.</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>Long term care plans are evaluated by the RNs six monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals. A six monthly multi-disciplinary review (MDR) is also completed by the registered nurse with input from caregivers, the GP, the activities coordinator, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly. There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</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>Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The registered nurse interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the facility manager and registered nurse identified that the service has access to a wide range of support either through the GP, specialists, and allied health services as 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>There are policies regarding chemical safety and waste disposal. All chemicals were clearly labelled with manufacturer's labels and stored in locked areas. Safety datasheets and product sheets are available. Sharp's containers are available and meet the hazardous substances regulations for containers. The hazard register identifies hazardous substance and staff indicated a clear understanding of processes and protocols. Gloves, aprons, and goggles are available for staff. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Moderate</p>	<p>The building holds a building warrant of fitness which expires June 2021. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged, expiring August 2021. The hoist and scales are checked annually and are next due to be checked July 2021. Hot water temperatures have been monitored in resident areas and are within the acceptable range. Internal flooring is safe and appropriate for residential care. All corridors have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. There are landscaped gardens and decked areas. All external areas have attractive features, including raised garden beds and ornamentation. All outdoor areas have some seating and shade.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All resident rooms have hand washing facilities. There are also sufficient communal toilets and showers. Handrails are appropriately placed in communal showers and toilets. There is ample space in toilet and shower areas to accommodate shower chairs and a hoist if appropriate. Communal toilet and shower facilities have a system that indicates if it is engaged or vacant. Resident privacy is assured. Fixtures, fittings, floorings, and wall coverings are in good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is one double room (not currently occupied), all other resident's rooms are single. There is sufficient space to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have more than adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the day of audit.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There are large and small communal areas. There is a dedicated activities lounge; however, activities occur in all areas of the facility, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. There are two dining areas which are inviting and appropriate for the needs of the residents.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is done on site. There are clearly defined clean and dirty areas with floor markings and signage to guide staff. There is a cleaning manual available. Cleaning and laundry services are monitored through the internal auditing system. The cleaners' equipment was attended at all times or locked away in the cleaners' cupboard. All chemicals on the cleaner's trolley were labelled. Sluice rooms were kept locked when not in use.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for 3 litres per person, per day for at least 3 days for resident use on site. The service has its own diesel generator on site.</p> <p>There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. Fire safety is completed with new staff as part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>All bedrooms and communal areas have ample natural light and ventilation. All heating is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</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>The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control officer (ICO) is an RN who is responsible for infection control across the facility as detailed in the infection control officer job description (signed copy sighted on day of audit). The ICO oversees infection control for the facility, reviews</p>

		<p>incidents and is responsible for the collation of monthly infection events and reports. The facility management team are responsible for the development of, and annual review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There have been no outbreaks since the last audit.</p> <p>An organisational Covid strategy and pandemic plan was available to staff on site with links to education and associated resources relating to hand hygiene, PPE, and donning/doffing procedures. Covid-19 education was also provided for all residents, including hand hygiene and use of PPE. These details were also passed on to families via email and in writing. During Covid lockdown the service implemented weekly staff toolbox talks which allowed for updates, education, and discussion. Staff household bubble tracking was implemented and a system whereby all staff had separate outdoor shoes to those worn in the facility initiated.</p> <p>All visitors are required to provide contact tracing information.</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>There are adequate resources to implement the infection control programme at Eversleigh. The infection control officer liaises with the infection control committee who meet regularly and as required (more frequently during Covid lockdown). Information is shared as part of staff meetings and also as part of the registered nurse meetings. The infection control officer has completed annual training in infection control through the local DHB.</p> <p>External resources and support are available through online learning portals, external specialists, microbiologist, GP, wound nurse and DHB when required. The GP and pharmacy monitor the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and</p>	<p>FA</p>	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for</p>

<p>control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the facility management team with input from the DHB infection control specialist.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control officer is responsible for coordinating education and ensuring staff complete the in-service and external training available. Training on infection control is included in the orientation programme. Staff have completed infection control education in the last 12 months. The infection control officer has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Eversleigh Hospital surveillance policy. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified, and analysed, corrective actions and preventative measures put in place. These, along with outcomes and actions are discussed at the registered nurse and staff meetings. Meeting minutes are available to staff.</p> <p>Infections are entered into an internal spreadsheet to facilitate trend analysis. Corrective actions are established where trends are identified.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers,</p>

<p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>At the time of the audit the service had three residents using restraints (two bed rails and one lap belt) and two residents using an enabler (bedrail). The care plans for one resident file with restraint and two files with enablers reviewed, were up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the resident and family is also identified.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to the facility manager (registered nurse). Staff receive training in the safe use of restraint (2020 and 2021).</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. A restraint assessment tool meets the requirements of the standard. One resident file where restraint was being used was reviewed. The files included a restraint assessment and consent form that was signed by the resident's family. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>A restraint register is in place. The register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and ongoing evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Restraint use is reviewed monthly during the quality improvement meetings. The review process includes discussing whether continued use of restraint is indicated.</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>Individual approved restraint is reviewed at least three-monthly as part of restraint evaluations. Restraint usage throughout the organisation is also monitored regularly and reported monthly. The service has continued to actively work on minimising the use of restraint and on the day of audit, the three restraints in use were at the request of family.</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 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	A business plan for 2020 is documented. The plan has not yet been reviewed and a new business plan for 2021 is yet to be documented.	The 2020 business plan has not been reviewed annually and a new business plan for 2021 is yet to be documented.	<p>Review the 2020 business plan and document a new business plan for 2021.</p> <p>180 days</p>
<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 Low	Policies and procedures are expected to be reviewed at least three yearly and when there are changes (e.g., to legislation). Most policies have been reviewed; however some policies have not been reviewed three yearly or in responses to changes. These include the infection control policies, emergencies (noting that Covid-19 policies are well documented), and the privacy policy which has not been	Not all policies have been reviewed three yearly or in response to changes in legislation.	<p>Review policies at least three yearly or in response to changes in legislation.</p> <p>180 days</p>

		reviewed to reflect changes in legislation.		
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Moderate</p>	<p>There is a monthly staff/quality/risk/safety meeting that includes tabling of data. Data for 2021 from incident forms was checked against the data collation forms and this was documented accurately. The data in meeting minutes was not as per the collation of data forms. The minutes for 2021 were duplicated (i.e., the minutes for January and February 2021 were the same and the minutes for March and April 2021 were the same). The meeting minutes do not reflect discussion of data or potential improvements as a result of review of data or trends.</p>	<p>The monthly minutes are inaccurate and do not reflect discussion of data.</p>	<p>Document accurate data and discussion related to data in the monthly meeting minutes and evidence use of data to improve services.</p> <p>90 days</p>
<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>	<p>PA Moderate</p>	<p>The satisfaction survey was completed in November 2020. Areas for improvement were identified in the feedback including 67% satisfaction with food services, 78% satisfaction with the environment and cleaning services, and 90% satisfaction with staff. Comments also indicated themes that should be included in the corrective action plan. There is no corrective action plan documented or evidence to show that services have been improved as a result of the feedback provided.</p>	<p>A corrective action plan to address the issues raised in the November 2020 satisfaction survey has not been documented or changes in response to feedback made.</p>	<p>Document and implement a corrective action plan to address the issues raised in the November 2020 satisfaction survey.</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,</p>	<p>PA Moderate</p>	<p>The service utilises an electronic medication management system. The Wi-Fi in the facility is not of a sufficient standard to allow the medication system to be utilised safely. The registered nurses' resort to operating the medication management system on their own</p>	<p>The Wi-Fi is not of a sufficient standard to allow safe and consistent operation of the electronic medication</p>	<p>Ensure there is sufficient infrastructure for the medication management system to operate safely.</p>

storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		phone as witnessed on day of audit and the GP describes this as a 'safety issue', having had regular issues accessing resident medication records within the facility.	management system.	30 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Moderate	There was one rest home and one respite resident who self-medicated. Both had current competencies signed by the RN. The GP had signed the rest home resident's assessment which was reviewed three-monthly. Not all requirements for self-medication had been met.	(i). One respite resident did not have an assessment to self-medicate signed by the GP. (ii). The self-medicating residents did not have lockable medication storage.	(i)-(ii). Ensure self-medication practices align with the policy. 30 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Registered nurses (RNs) are responsible for the residents' assessments and the development of nursing care plans. The review of the residents' files reflected that not all documentation was completed within expected timeframes.	(i) One rest home, two hospital and residents did not have interRAI assessments and long-term care plans completed within 21 days of admission. (ii) One respite resident did not have admission assessments, or an initial care plan completed despite having been in the service for over three weeks.	(i) Ensure an interRAI assessment and long-term care plan is completed within 21 days of admission. (ii) Ensure admission assessments and initial care plans are completed for all residents according to policy timescales. 60 days
Criterion 1.3.6.1 The provision of services and/or	PA Low	There are clear indications, requirements and timescales related to neurological observations in the organisation's policy. However, not all	Neurological observations were not consistently documented	Ensure neurological observations are documented as per the

interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.		neurological observations were carried out and documented as per that policy.	according to organisational policy for six of eight falls which required neurological observations.	organisation's policy. 60 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	There is a well organised activities programme for both rest home and hospital residents, however attendance and participation are not documented.	Resident attendance and participation in activities are not documented.	Document all resident participation in planned activities. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There is a planned and reactive maintenance programme however some areas of the facility are in a poor state of repair.	(i). There are broken vinyl floor seams in the kitchen (next to chiller) and missing vinyl flooring in front of the steriliser. (ii). The kitchen steriliser and hot water zip were out of order during the days of audit.	(i)- (ii). Ensure all buildings and equipment comply with legislated standards. 60 days
Criterion 1.4.2.6 Consumers are provided with safe and accessible external areas that meet their needs.	PA Moderate	There are outdoor areas for each of the wings that provide walking areas. One external pathway had uneven flooring, extensive broken concrete surrounding a tree in the middle of the path and wooden ramps without a non-slip covering.	There was broken, uneven and slippery walking areas in one area posing a slip and/or trip hazard.	Ensure all outdoor areas are safe and that walking paths are well maintained. 30 days

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.