# Waikanae Country Lodge Limited

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Waikanae Country Lodge Limited

**Premises audited:** Waikanae Country Lodge

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

**Dates of audit:** Start date: Choose a date End date: 11 February 2015

**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:** 56

# 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** |
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|  | 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 |
|  | 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

Waikanae Country Lodge provides hospital and rest home level care for up to 79 residents and on the day of the audit there were 56 residents. There is an experienced facility manager who has been in this role since December 2013. The manager is supported by a clinical leader who has been in the same role since the previous audit. Waikanae Country Lodge has a current business plan which outlines the service direction. The quality and risk management programme is fully implemented and reviewed annually.

This unannounced surveillance audit was conducted against a sub–set of relevant Health and Disability standards and contract with the District Health Board. The audit process included review of policies and procedures, review of residents and staff files, observations and interview with residents, families, staff and management.

Waikanae Country Lodge has addressed nine of the ten previous audit shortfalls. An improvement continues to be required around electrical testing. This surveillance audit identified improvements required in relations to aspect of food services, hazard register and advanced directives.

## Consumer rights

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

Open disclosure principles are implemented and open disclosure is included in the consumer rights training. A residents/relatives meeting occurs and issues arising from the meetings are communicated to staff. Relatives are informed when any untoward event occurs and the registered nurse on duty is responsible for this. This is overseen by the clinical leader and the facility manager. An improvement is required around implementation of the advanced directives.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Waikanae Country Lodge has continued implementing their quality and risk management programme since previous audit. Corrective actions and service deficits have been identified, actioned and improvements in overall performance of the service have occurred.

Resident/relative surveys are undertaken as per quality programme and last completed in 2014. Overall result shows satisfaction with services provided.

Annual staff training programme is implemented. Staff files are maintained by the human resource manager who works for several facilities under the same company. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training and support. Completed orientation is on files and staff described the orientation programme. Staff performance appraisals are completed annually.

Caregivers are encouraged and supported to undertake external education including national qualification in care of elderly. The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Staff are qualified/skilled and up to date in their knowledge. Staffing rosters sighted and there is staff on duty to match needs of different shifts. This audit identifies an improvement required around the hazard register.

## Continuum of service delivery

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| 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. |  | Some standards applicable to this service partially attained and of low risk. |

The sample of residents’ records reviewed provides evidence that Waikanae Country Lodge has implemented systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed on a regular basis with the resident and/or family/whanau input. Care plans demonstrate service integration. Care plans are reviewed six monthly, or when there are changes in health status. Resident files include notes by a general practitioner and allied health professionals. Medication policies and procedures are in place to guide practice. Education and medication competencies are completed by all staff responsible for administration of medicines.

The activities programme is facilitated by a diversional therapist. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs. Community activities are encouraged; van outings are arranged on a regular basis. All food is cooked on site by the in-house cook. All residents' nutritional needs are identified on admission and reviewed at least six monthly. Meals are well presented.

## Safe and appropriate environment

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| 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. |

The building has a current building warrant of fitness. There are regular checks of the building and equipment documented and carried out by the maintenance person. Required corrective actions around replacement of broken wall vinyl in the bathrooms, skirting board and dining room door paintings have been completed. An annual service of medical equipment has occurred, but not all electrical equipment checked and tagged.

## Restraint minimisation and safe practice

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| 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. |

Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and the use of enablers. There were five residents with enablers and five residents requiring restraint. Document review confirmed that the service actively works towards minimising use of restraint.

## Infection prevention and control

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| 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. |

The surveillance programme has been implemented and monthly surveillance activities occur. The infection control coordinator is responsible for ensuring effective monitoring occurs. The service conducts regular audits on aspects of the infection control. Results of data analysis is reported to and discussed at the integrated quality and staff meetings.

## Summary of attainment

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

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| **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 | 14 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 4 | 0 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | Waikanae Country Lodge provides information for residents, families and enduring power of attorneys (EPOA) to make informed decisions. There is documented evidence of consents signed and dated by residents where appropriate, families or EPOAs. There are implemented advance directives around resuscitation. Not all advance directives have been signed by residents. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints folder and register that includes complaints verbal and written. The register contains sign-off with evidence of follow up and resolution. Investigation results are given to the complainant and this letter includes information around right to appeal the facilities’ decision and contact details of the external organisations. A progress letter has been given to a complainant when an investigation has taken more than 10 days. This is noted to be an improvement since previous audit.  Families/ residents interviewed stated that any issues are addressed and they feel comfortable to bring up any concerns. All staff interviewed were able to describe the process around reporting complaints.  Records demonstrate that complaints are well managed. Waikanae Country Lodge is active in documentation and review of complaints. There have been 25 complaints in 2014 and three complaints in 2015 to date. All have been appropriately resolved.  There is one complaint investigations by the Health and Disability Commissioner and the coroner since the previous audit and this complaint is closed off. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Open disclosure principles are implemented. Review of 10 incident forms identified that relatives in all cases had been notified where appropriate.  A residents/relatives meeting occurs and issues arising from the meeting are communicated to staff. Any issues raised from these meetings are investigated by the facility manager and there was evidence of implemented corrective actions. Relative’s interview (two rest home) also confirmed this.  Open disclosure is included in the consumer rights training.  D12.1: 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 Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.  D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.  D16.4b: Two family members interviewed stated that they are always informed when their family members health status changes.  D11.3: The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Waikanae Country Lodge provides care for up to 79 residents with 59 dual-purpose beds and up to 20 serviced apartments certified to provide rest home level care. The occupancy on the day of audit was 56 residents including 22 rest home and 34 hospital residents. There were no rest home level residents in the serviced apartments.  In December 2014, Waikanae Country Lodge merged companies with Arvida Group. The former owner has taken the general manager position for 18 months and his office remains on site.  There is a facility manager who has been in this role since December 2013 and she is an experienced facility manager with five years’ experience in similar positions in NZ. She is supported by a clinical leader who has been in the same role since the last audit.  Waikanae Country Lodge has a current business plan which outlines the service direction. The quality and risk management programme is fully implemented and reviewed annually.  ARC, D17.3di (rest home), D17.4b (hospital): The Clinical Leader and the Facility Manager have completed on-going training appropriate to their positions. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The quality programme is supported by all staff and the required corrective action from the previous audit has been addressed. Meeting minutes reviewed included all quality data and responsibilities.  Waikanae Country Lodge continue to implement their quality and risk management programme, corrective actions and service deficits have been identified, actioned and improvements in overall performance of the service have occurred.  Resident/relative surveys are undertaken as per quality programme and last completed in 2014. Overall result shows satisfaction with services provided. Resident meetings occur and resident interviews (six) confirmed this.  D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans and use of hip protectors. Analysis of incident and accidents occurs and these are used in changes in duty allocation to accommodate high risk areas particularly time of the incident.  Incidents and accidents are reported on the prescribed form and recorded on a monthly summary sheet. Complaints are documented in the complaints register. An infection rate monthly summary is completed. There is a hazard register that is reviewed annually but hazard register was not up to date.  The internal audit programme continues to be implemented and all issues identified had corrective action plans and resolutions. All staff interviewed could describe the quality programme corrective action process.  There is an annual staff training programme that is implemented and based around policies and procedures and records of staff attendances maintained. Infection Control programme is implemented and all infections are documented monthly. A monthly IC report is completed and provided to integrated quality and staff meetings.  D5.4: The service has the following policies/ procedures to support service delivery; Policies and procedures align with the resident’s care plans.  D10.1: Care of the deceased resident process and policy that outlines immediate action to be taken upon a resident’s death and that all necessary certifications and documentation is completed in a timely manner.  D19.3: There are implemented risk management, and health and safety policies and procedures but the hazard register was not up to date. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | Waikanae Country Lodge collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. Incidents/accidents are documented; reporting of incidents occurs and monitored with action taken on trends. Clinical follow up occurs for incidents and accidents and documentation to demonstrate follow up has improved since last audit. Ten incident and accident forms reviewed identified follow up completed by the RN soon after the reporting, including neuro-obs completed following a fall with potential head injury. All incident forms were investigated and signed off by the Clinical Leader. Therefore required corrective action from the previous audit has been addressed.  Discussion with the Facility Manager and the Clinical Leader indicated that management are aware of and are able to describe their statutory requirements in relation to essential notification. Examples given to this are, notification to the local DHB regarding wandering incident of a resident out of facility, notification to public health authorities and the local DHB regarding infectious outbreak and notification to the Coroner’s Office following an unexpected death.  D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Staff files are maintained by the human resource manager who works for several facilities under the same company. There are job descriptions established and appropriate human resource policies/procedures in place for staff recruitment, training and support. Staff orientation programme is established and includes a programme/checklist for completion. Completed orientation is on files and staff described the orientation programme. Staff performance appraisals are completed annually and eight files reviewed had up to data performance appraisals. Staff interview also confirmed that performance appraisals occur annually and they receive feedback regarding their performance on a regular basis. This is an improvement since the previous audit.  There is a documented in-service programme for education. Competencies are identified and completed. Caregivers are encouraged and supported to undertake external education including national qualification in care of elderly. Staff training audit shows 75% compliance in 2014 and the required corrective actions were completed. Staff requiring training identified and special training opportunities were facilitated for this group. There are five staff members who are rostered for night duties and training requirements of these staff are monitored and all have completed minimum 10 hours training annually. This is an improvement since the previous audit. Interview with the Facility Manager confirmed that the service exploring opportunities for further improvement in attendance of staff training.  Registered nurses accessed on-going clinical training provided by the local DHB. Discussions with the caregivers and the RNs confirmed that on-going training is encouraged and supported by the service.  D17.8 Eight hours of staff development or in-service education has been provided annually. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Staff are qualified/skilled and up to date in their knowledge. The service has a total of 70 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts.  Care staff reported that staffing levels and the skill mix is appropriate.  Clinical Leader and a senior RN share on call duties.  Residents (four rest home and two hospital) and relatives (two rest home) and staff interviews (four caregivers and three RNs) confirm there are sufficient staff to meet the needs of residents. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | Waikanae Country Lodge has comprehensive medication policies. Medication storage and administration follow safe guidelines. Medication reconciliation is completed on admission and the policy includes guidelines on checking medications on admission.  All staff administering medication have completed an annual medication competency. This is an improvement from the previous audit.  Fourteen medication charts were reviewed (five rest home, nine hospital level). They were legible and meet legislative guidelines. Ten of the 14 medication charts sampled have photographic identification. Signing on administration was up to date, including as required medications (PRN). All PRN medications had indication for use identified on the medication chart. All medication charts identified any allergies. Fourteen medication charts reviewed had written evidence of the GP three monthly reviews, or more as conditions changed, all had been signed and dated. All medications prescribed to be administered regularly were signed as being administered regularly. Weekly medication checks documented. The pharmacy completes a six monthly audit. There were no expired medications on the day of audit. The medication fridge is monitored for temperatures. Blood sugar levels are documented for insulin dependent diabetic residents. These are improvements since the previous audit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | The service employs a cook and assistant cook to cover seven days, as well as kitchen assistants. Fridge temperatures are monitored and documented daily in the kitchen. There were containers of food not dated and some food in the fridge not covered in the kitchen fridge. This is an area of improvement. Meals are prepared in the kitchen and delivered to the rest home, hospital dining rooms.  There are nutritional assessments and management policy and a weight management policy.  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 are communicated to the kitchen as reported by the kitchen manager. Special diets are noted on the kitchen notice board which is able to be viewed only by kitchen staff. Special diets are catered for. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Six resident files reviewed identified documented evidence of pain assessments completed for those residents’ who are charted analgesia. Assessments were completed also for change of care level. These were identified as findings during the last certification audit and have now been rectified. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Six resident files were reviewed; two rest home and four hospital level. The care plans were well documented and included interventions to support care required.  When a resident's condition alters, the clinical manager initiates a review and if required, GP or specialist consultation. The caregivers (four) interviewed stated that they have all the necessary equipment referred to in care plans to provide care. All staff report that there are always adequate continence supplies and dressing supplies.  All six residents (four rest home and two hospital) interviewed reported their needs were being appropriately met. There is a short-term care plan that is used for acute or short-term changes in health status.  D18.3 and 4: Dressing supplies are available and a treatment room is stocked for use.  Wound assessment and wound management plans are in place for seven residents. There is one pressure areas identified in the service. All wound assessments have completed short term care plans describing appropriate interventions. All wounds have been reviewed in the timeframes identified. |
| Standard 1.3.7: Planned Activities  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. | FA | There is a diversional therapist who works in both the rest home and hospital areas. There is a full and varied activities programme in place which is appropriate to the level of participation from residents. On the day of audit residents were observed being actively involved with a variety of activities. The programme is developed weekly and displayed in large print in communal areas and resident bedrooms. Residents’ and families interviewed voiced their satisfaction of the activities programme and felt that recreational needs were being met. Residents have an activities assessment completed over the first few weeks.  D16.5d: Resident files reviewed identified that the individual activity plan is reviewed when the care plan is reviewed. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans are reviewed and evaluated by an RN at least six monthly, or as changes to care occur as sighted in all care plans sampled. This is an improvement since the previous audit.  ARC: D16.3c: All initial care plans are evaluated by the RN within three weeks of admission. There is documentation evidence of family and/or resident involvement at these evaluations.  Documentation on clinical notes evidenced review by the GP at least three monthly. There are short-term care plans to focus on acute and short-term issues. This is an improvement since the previous audit. Examples of short-term plan use included; infections and wounds. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building has a current WOF. There are regular checks of the building and equipment which is documented and carried out by the maintenance person. Required corrective actions around replacement of broken wall vinyl in the bathrooms, skirting board and dining room door paintings have been completed. Annual services of medical equipment occurred but not all electrical equipment were checked and tagged. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance programme has been implemented and surveillance activities occur monthly. The infection control coordinator is responsible for ensuring effective monitoring occurs. The service conducts regular audits on aspects of the infection control. Results of data analysis is reported to and discussed at the integrated quality and staff meetings. Actions are taken to reduce the infection rates according to the surveillance results. An interview with the GP confirmed that resident’s infections and antimicrobial usage is reported. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, included definitions, processes and the use of enablers. The Restraint Minimisation Manual includes that enablers are voluntary and the least restrictive option. There are five residents with enablers and five residents requiring restraint. Document review confirmed that the service actively work towards minimising use of restraint. Staff interview confirmed sound understanding around use of restraint and enablers. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Low | There are policies and procedures in place for advanced directives and resuscitation orders. Two of six files had an appropriately signed resuscitation order. | In the six resident files reviewed there were four ‘Not for Resuscitation’ signed by families or EPOA. | Ensure that resuscitation orders are signed by the resident.  60 days |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (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; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Low | D19.3: There are implemented risk management, and health and safety policies and procedures but the hazard register was not up to date. Since the draft report the provider stated; a new Health & Safety Officer has been appointed and tasked to review and update the hazard register - which is now updated. | Hazard forms are available for use and staff interview and document review confirm that this forms are well utilised. However the hazard register was not up to date. Health and Safety officer who reviews the hazards register had recently resigned from the position and the successor has not been recruited yet. | Ensure the hazard register is updated and reviewed regularly  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Waikanae Country Lodge has policies and procedures regarding the safe storage of food. There are small food fridges situated in the hospital and dining room. All food stored in all fridges have daily temperature recordings monitored. Food containers in the small fridge in the hospital dining room and are dated and labelled. | There were containers of food in the kitchen fridge which were not labelled or dated. There was some food in the kitchen fridge that was uncovered and not dated. | Ensure all food complies with safe storage policies and include labels identifying the food and date and that all food is covered when stored in the fridge.  90 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | Since the previous audit, the service had employed an external contractor to undertake checking of all electrical equipment. | Not all electrical equipment has been checked and tagged. | Ensure that electrical testing of equipment occur.  90 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| No data to display |

End of the report.