

Ativas Limited - Cairnfield House

Introduction

This report records the results of a Certification Audit; Partial 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 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](#).

The specifics of this audit included:

Legal entity:	Ativas Limited
Premises audited:	Cairnfield House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 July 2015 End date: 28 July 2015
Proposed changes to current services (if any):	Reconfiguration of 15 rest home level beds to hospital level of care.
Total beds occupied across all premises included in the audit on the first day of the audit:	59

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Cairnfield House provides rest home and hospital level care for up to 66 residents. On the day of the audit there were 59 residents. The service is managed by a facility manager and a clinical manager. The residents and relatives interviewed spoke positively about the care and support provided.

This certification and partial provisional audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management, staff and a general practitioner.

The facility manager is appropriately qualified and experienced. She has been in her role for two years. She is supported by a clinical manager/registered nurse.

This audit included a partial provisional to assess the appropriateness of 15 rest home level rooms as suitable for hospital level care (dual purpose).

Improvements are required around open disclosure, analysing accident and incident data, implementing corrective actions, staffing related to the additional hospital level beds, back-up of electronic data, integrated residents' files, admission agreements, care plans, interventions, evaluations, activities, medication management, food allergies and menu reviews.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with dignity and respect. Written information regarding consumers' rights is provided to residents and families during the admission process. The residents' cultural, spiritual and individual values and beliefs are assessed on admission and are being met by the service. Evidence-based practice is evident, promoting and encouraging good practice. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Business goals are documented for the service with evidence of reviews. A system is in place for the collation of quality and risk data that is regularly collected. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. On-going education and training is in place for staff.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents report staffing levels are adequate to meet their needs. The residents' files are appropriate to the service type.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Residents are screened and approved prior to entry to the service. There is a comprehensive admission package available prior to or on entry to the service. Registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals. Care plans viewed in resident records demonstrated service integration and were reviewed at least six monthly. Residents' files included medical notes by the contracted GP, and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete education and medication competencies. The medicine charts sampled were reviewed at least three monthly by the general practitioner.

An activities coordinator provides the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. The building has a current warrant of fitness.

Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are spacious and personalised with access to shared ensuites or communal facilities. Emergency systems are in place in the event of a fire or external disaster.

Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

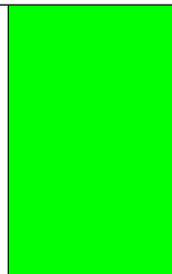


Standards applicable to this service fully attained.

Restraint policy and procedures are in place. The definitions of restraints and enablers are congruent with the definition in the restraint minimisation standard. The service had two residents at a hospital level of care using an enabler. A register is maintained by the restraint coordinator. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	34	0	7	4	0	0
Criteria	0	80	0	9	4	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>There is an implemented policy on residents' rights to guide practice. Discussions with care staff (five healthcare assistants who work across the rest home and hospital, three registered nurses (RNs), one activities coordinator) confirmed their understanding of the Code of Health and Disability Consumers' Rights (the Code). Interviews with nine residents (three hospital level and six rest home level) and four relatives (three with family at hospital level of care and one with family at rest home level of care) confirmed the service is provided in line with the Code. Staff training on the Code begins during their orientation to the service and continues regularly as an in-service topic.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There are established informed consent policies/procedures and advanced directives. General consents are obtained on admission as sighted in all eight resident files sampled (four rest home, and four hospital). Advance directives if known were on the resident files reviewed. Resuscitation plans were sighted in the files and were signed appropriately. Copies of enduring power or attorney (EPOA) were on all files and activated as required. Residents and relatives confirmed that they were provided with adequate information to make</p>

		informed choices.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Residents are provided with a copy of the Code and HDC Advocacy Services pamphlets on entry. Interviews with the facility manager and staff described how residents are informed about advocacy and support. Residents and families identified that the service involves them in decision-making. They confirmed that they are aware of their right to access advocacy support. Advocacy services were utilised for a complaint received in June 2015.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	All families interviewed stated they could visit at any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit. The activities programme encourages links with the community. Activities include opportunities to attend events outside of the facility including shopping and visits to the residents' homes. Interviews with the rest home level residents confirmed that the activity staff help them access the community.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives during entry to the service. A record of all complaints is maintained by the facility manager using a complaints' register. Only one complaint has been received in 2015 (year to date). This complaint was reviewed and reflected evidence of responding to the complaint in a timely manner with appropriate follow-up actions taken. This complaint has been signed off by the facility manager as resolved but there was no evidence to reflect discussion with (applicable) staff regarding the complaint received (link 1.2.3.7).</p> <p>Discussions with residents and families confirmed they were provided with information on complaints during their entry to the service. Complaint/concern forms are located in a visible location at the entrance to the facility. Residents and families confirmed that they are comfortable speaking with the facility manager if they have a concern/complaint and that concern/complaint is dealt with promptly.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	The Code, posters and brochures are displayed in public areas of the facility. The information pack given to prospective and admitted residents and their families includes pamphlets on the Code and the Health and Disability Advocacy Service. The admission agreement

		contains information relating to residents' rights. Interviews with residents and family confirmed that residents' rights were explained during the admission process. They also confirmed that residents' rights were being upheld by the service. Residents' meetings provide opportunities to discuss aspects of the Code.
<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>There is an implemented policy supporting the privacy of residents. Residents' rooms are single, with only one double room that is occupied. Consent processes and visual privacy are upheld. Privacy signage and locks are on public toilet and shower doors. Discussions with residents and relatives confirmed their privacy is respected with examples provided.</p> <p>The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. A satisfaction survey is planned annually to gain feedback but the number of responses have been three or less. Eight residents' files reviewed (four rest home level and four hospital level) confirmed that cultural and/or spiritual values and individual preferences are identified.</p> <p>Residents are supported and encouraged to maintain their independence, confirmed in interviews with staff and residents. A physiotherapist is on-site as needed. He was available during the audit and confirmed that he regularly assesses residents who demonstrate rehabilitation potential.</p> <p>The abuse/neglect policy includes definitions and the process for reporting to ensure resident safety. Abuse and neglect training is included in the staff orientation programme and as a regular in-service topic. Staff are trained to report any concerns.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>There is a Maori health plan in place. There are four residents at hospital level of care who identify as Maori. One whanau interviewed, reported that the resident's cultural needs are being met by the service. Discussions with staff confirmed their understanding of the cultural needs of residents, including the importance of involving whanau in the delivery of care. Staff receive regular education and training around Maori values and beliefs (e.g., death and dying).</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>A culturally appropriate service is provided, which includes assessing residents' needs on admission. Individual values and beliefs are identified through the assessment and care planning process, although there was a lack of documented evidence in the residents' care plans to verify that family have input into the care planning process (link to finding 1.3.4.2). Staff and family are available as interpreters if needed.</p> <p>Families and residents interviewed expressed their satisfaction with the services that the residents are receiving.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Policies outline the service's responsibilities to ensure residents are not subjected to discrimination, coercion, harassment, and sexual or other exploitation. Education and training is provided to staff, around professional boundaries, code of conduct, abuse and neglect and residents' rights. Professional boundaries are assessed in staff performance appraisals.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence-based practice is supported, promoting and encouraging good practice. Registered nursing staff are available seven days a week, 24 hours a day. Residents identified as stable are reviewed by the general practitioner (GP) every three months, with more frequent visits scheduled for those residents whose condition is not deemed stable.</p> <p>The service receives support from the Northland District Health Board (NDHB) and local community hospice services. Examples include visits from the NDHB mental health team and palliative care nursing visits by the community hospice. A physiotherapist is available on an as-needed basis.</p> <p>There is a regular in-service education and training programme for staff that exceeds contractual requirements. Staff competency assessments are completed for medication, hand hygiene, health and safety, and manual handling. All healthcare assistant staff receive supervision by registered nurses.</p> <p>The service has maintained links with the local community and encourages their active residents to remain independent with examples provided. Residents interviewed spoke positively about the care and support provided. Care staff interviewed stated that they are supported</p>

		with their professional development.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>Policies and procedures relating to accident/incidents and open disclosure identify staff responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whanau is recorded on the accident/incident form and in the residents' progress notes. Ten of fifteen accident/incident forms that were reviewed across the rest home and hospital identified family are kept informed. The remaining five accident/incident forms for two residents identified that family did not wish to be contacted. The clinical manager reports this information received from families was held on her computer but was not available for sighting (link 1.2.9.7). Family interviewed stated that they are kept informed when their family member's health status changes.</p> <p>Contact details of available interpreters are available. Staff and family assist as they are able. The information pack is available in large print and is read to residents who require assistance.</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 residents and family are informed prior to entry, of the scope of services and any items they have to pay that are not covered by the agreement.</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>	FA	<p>The facility is owned by Ativas Limited and is managed by a fulltime facility manager. Care is provided for up to 66 residents across rest home and hospital levels of care. On the day of audit there were 37 rest home level residents (out of 41 available) and 22 hospital level residents (out of 25 available). The service has applied to HealthCert for the approval of 15 current rest home level beds as suitable for hospital level of care and was included as part of this audit.</p> <p>The owner maintains an onsite office and is present most days although was not available during the audit. There is a business plan for 2015 that outlines objectives and actions for the period. The purpose, values, scope, direction, and goals of the organisation are identified and regularly reviewed.</p> <p>The facility manager is a registered diversional therapist who</p>

		<p>commenced employment at the facility 21 years ago as a healthcare assistant and has progressed through various roles since then. She was appointed to the role of facility manager in September 2013. She is supported by a clinical manager who is a registered nurse (RN) with a current practising certificate and experience in the aged residential care industry.</p> <p>The facility manager and the clinical manager has maintained at least eight hours annually of professional development activities related to managing an aged residential care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the facility manager, the clinical manager/RN covers the facility manager's role.</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 Low	<p>A 2015 quality and risk management programme is in place. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are reviewed two yearly unless changes occur more frequently. Policies and procedures have been updated to include reference to InterRAI for an aged care service. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Interviews with the facility manager, clinical manager and staff, reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>Data collected is collated, and trended but is not being analysed, evaluated and used for service improvements. Quality and risk management results are not regularly discussed with staff. Internal audits are completed but not as documented in the audit schedule. Corrective actions are documented on a corrective action form where internal audits identify opportunities for improvements but are not signed off when implemented.</p> <p>Falls prevention strategies include the use of sensor mats and</p>

		<p>implementing strategies for frequent fallers (link 1.3.6.1).</p> <p>A health and safety programme is in place. Hazard identification forms and a hazard register evidence the monitoring of hazard controls. Staff education, which begins during their induction to the service, includes the topic of health and safety.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Individual reports are completed for each incident/accident with immediate action noted including any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes (link 1.2.3.6). Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse.</p> <p>The facility manager and clinical manager were aware of their responsibility to notify relevant authorities in relation to essential notifications. Evidence of essential notification was documented following a recent norovirus outbreak.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resources policies address recruitment, orientation and staff training and development. Eight staff files that were randomly selected for review (four healthcare assistants, one registered nurse, one clinical manager, one cook, one cleaner) included evidence of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service. Current annual practising certificates were sighted for the registered health professionals.</p> <p>There is an annual education and training schedule that exceeds eight hours per annum. Careerforce education and training is undertaken by the healthcare assistants with the clinical manager an approved Careerforce assessor. Education and training for registered nursing (RN) staff is supported by the NDHB. Seven of the eight RNs have completed their InterRAI training. Competency assessments are in place for medication management, health and safety, behavioural management, manual handling and hand washing. Two yearly chemical safety training is in place with evidence of the kitchen staff</p>

		and cleaning staff attending.
<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>	PA Low	<p>The staffing levels meet contractual requirements. The clinical manager is a registered nurse who is available during weekdays. On-site RN cover is provided 24 hours a day, seven days a week. RNs are supported by sufficient numbers of healthcare assistants with a seven to one (residents to healthcare assistants) ratio. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p> <p>Partial Provisional:</p> <p>Plans are in place to provide an additional four hours of RN cover three days a week based on the current resident level of acuity. A staffing plan for the reconfiguration of 15 rest home level beds to hospital level only states that 'the hospital level staff numbers will increase to a level which is safe and within the safe guidelines to meet contractual requirements' and is no more specific than this. The service has not determined how many more staff will need to be employed to cover the increase in hospital residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>The resident files are appropriate to the service type. Residents entering the service have relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is developed in this time. The RNs are currently in the process of completing InterRAI assessments for the residents. All new admissions (effective 1 July 2015) have an InterRAI assessment completed.</p> <p>Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in secure metal filing cabinets. Archived records are stored securely in a locked room on the premises.</p> <p>The clinical manager has been storing information relating to family communication and open disclosure on her computer. There is a lack of evidence to reflect this information being integrated into the hard copy residents' files. Several months of electronic information has recently been reported by the RN as 'lost' without any back-up systems in place to retrieve this information. Information technology consultants are currently working to develop more secure electronic back-up</p>

		<p>systems using cloud-based technology.</p> <p>Entries are legible, dated and signed by the relevant healthcare assistant or registered nurse. Entries include evidence of the time of entry and the staff member's designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	PA Low	<p>All residents are assessed prior to entry for rest home or hospital level of care. A placement authority form is sent to the receiving facility. The clinical manager is responsible for the screening of residents to ensure entry has been approved. A pre-admission checklist ensures the potential resident and family are shown around the facility and introduced to staff. An information booklet is given out to all residents/family/whanau on enquiry or admission.</p> <p>The information pack includes all relevant aspects of service, and associated information such as the Health and Disability Code of Rights and how to access advocacy. There is an admission procedure in place and admission documentation, which includes resident and next of kin details. The clinical manager (interviewed) was able to describe the entry and admission process. Discussion with the referrer/resident/family takes place and a suitable time is arranged for admission.</p> <p>The facility manager completes all admission documentation and relevant notifications of entry to the service. Three of eight resident files sampled did not have signed admission agreements on the day of audit. Residents and family interviewed stated they received all relevant information prior to or on admission. The GP is notified of a new admission.</p> <p>The admission agreement reviewed aligns with a) -k) of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</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 policies for transfer or exit of the service. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities, with a transfer letter from the facility photocopied with accompanying relevant documentation, including medication charts. When a resident wishes to leave the facility, the NASC service is</p>

		<p>notified as reported by the registered nurse. All relevant information is documented and communicated to the receiving health provider or service, notes are photocopied. The family members interviewed were satisfied that they were kept well informed about referrals and/or transfer to hospital where this had occurred. Staff could describe the referral and/or transfer processes and demonstrated an understanding of resident's right to be informed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed administering medications. One resident was observed being given a bedtime medication at teatime. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. All registered nurses are syringe driver competent. Two self-medicating residents had been assessed by the GP and RN as competent to self-administer.</p> <p>Twelve of 16 medication charts sampled met legislative prescribing requirements.</p> <p>The medication charts reviewed identified that the GP had seen and reviewed the residents three monthly.</p> <p>Partial Provisional:</p> <p>The current treatment room is sufficient for the increase of stock medication if required. Registered nurses will continue to administer medication to the increase in hospital residents.</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>PA Moderate</p>	<p>The food service policies and procedures are appropriate to the service setting. The facility manager reports that the menus have been reviewed by a dietitian, with the last review over two years ago. Copies of the residents' dietary profiles are kept in the kitchen. In interview, the cook confirmed they were aware of the residents' individual dietary needs although they had not received two residents' profiles of residents who had known food allergies. All kitchen staff have recently completed their safe food handling training.</p>

		<p>The residents' files demonstrated monthly monitoring of individual resident's weight. Decanted food stores are dated. In interviews, residents stated they were satisfied with the food service.</p> <p>The food temperatures are recorded as are the fridge, chiller, and freezer temperatures.</p> <p>Partial Provisional:</p> <p>The dining room is large enough to accommodate the increase in hospital residents. The service has access to a community dietitian as needed.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>There is an admission information policy. The reasons for declining entry would be if the service is unable to provide the specialised care required or there are no beds available. Management communicate directly with the referring agencies and family/whanau as appropriate if entry was declined.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>The RN completes an initial assessment on admission using information in discharge summaries, referral letters, medical notes and nursing care discharge summaries received from referring agencies. Files sampled included the InterRAI assessment tool. Residents' needs and supports are identified through the on-going assessment process (link 1.3.8.3). The residents' files sampled did not evidence resident family/whanau involvement in the care planning processes. The activities coordinator completes an activity assessment that identifies individual activities and preferences. Relatives and residents interviewed advised that assessments were completed in the privacy of the resident's own room.</p> <p>Cultural assessments are completed on admission for all residents. Cultural assessments were completed in all eight resident files sampled.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Resident care plans are resident focused. Four of eight residents' files reviewed identified sufficient documented support needs in the care plans (link 1.3.6.1 and 1.3.8.3). Medical GP notes and allied health professional progress notes were evident in the resident's integrated</p>

		<p>files sampled (link 1.3.4.2).</p> <p>Short-term care plans are used for short-term needs. Short-term care plans sighted in resident files were wounds, prevention of pressure injury and infection (link 1.3.8.3).</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 Moderate</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.</p> <p>Three hospital and one rest home resident did not have interventions documented for all identified care needs. Monitoring forms were not all completed as required or evaluated by a registered nurse. An activities plan is completed on admission and reviewed six monthly with the care plan review.</p> <p>Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP dietitian and specialist involvement in wounds/pressure areas. Three of four wound care plans had no documented evaluations.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The service has an activities coordinator who works 35 hours per week and is supported by six volunteers. The activities coordinator is currently completing the diversional therapy qualification. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. An activities assessment is completed on admission and an activity plan developed.</p> <p>Three of eight resident files sampled had no documented activity plan on day of audit. Activity participation sheets are maintained on the resident files sampled. The monthly programme is displayed on notice boards around the facility. There are regular outings/drives, inter-home visits for all residents' entertainment, women pamper sessions, men's groups and visits from kindergartens and schools. The activities</p>

		<p>coordinator holds a current first aid certificate. Residents and families commented positively on the activities programme.</p> <p>Residents' files reviewed, evidenced that the individual activity plan is reviewed when the care plan is reviewed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Long term care plans reviewed were evaluated six monthly. The GP reviews the residents at least three monthly or earlier if required. The multidisciplinary team (MDT) including the GP (interviewed) are involved in the care plan reviews. On-going nursing evaluations occur daily and were documented within the progress note. The long term care plans were not all updated following a change in health condition as identified acutely or through the care plan evaluation.</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 eight resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. (Examples of referrals sighted, were to mental health services for the older person, physiotherapist, hospital specialists, speech language therapist, wound nurse, podiatrist and dietitian). The service liaises closely with the needs assessment team, geriatrician, and mental health team for the older adult.</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>Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit. Blood and chemical spills kit are available.</p> <p>Partial Provisional:</p> <p>Processes are currently in place to safely manage waste and hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires on 1 June 2016. Planned and reactive maintenance systems are in place. Hot water temperatures are checked monthly and records show that</p>

		<p>they are maintained in a safe range.</p> <p>There is safe storage of medical equipment. Clinical equipment has had functional checks/calibration annually.</p> <p>Corridors are wide enough in all areas to allow residents to pass each other safely. The external areas are safely maintained and are appropriate to the resident group and setting and include seating and shade.</p> <p>Staff interviewed stated that they have all the equipment required to provide the level of care documented in the care plans.</p> <p>Partial Provisional:</p> <p>This audit has assessed fifteen currently 'rest home only' rooms as suitable for rest home or hospital level residents. All rooms are suitable for hospital level residents. There are extra dining areas and lounges that are large enough to cater for the equipment associated with the extra residents at the higher level of care. An equipment plan in place has identified the need for additional hospital level beds. This plan does not identify the need for an additional hoist although the facility manager reports that she has discussed this with the owner.</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>	<p>FA</p>	<p>Toilet and shower facilities are of an appropriate design to meet the needs of all residents. Communal toilet facilities have a system that indicates if it is engaged or vacant. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. There is a safe locking system on the bathrooms and toilets that provides for privacy but allows service providers access in case of emergency.</p> <p>Partial Provisional:</p> <p>There is sufficient communal mobility bathrooms for the increase in hospital residents.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p>	<p>FA</p>	<p>There are only single rooms with the exception of one double room with a couple residing in it. There is adequate room to safely manoeuvre</p>

<p>areas appropriate to the consumer group and setting.</p>		<p>mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms.</p> <p>Partial Provisional:</p> <p>The rest home level bedrooms identified for hospital level care are suitable in size to adequately care for hospital level residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There is adequate access to lounge, dining and other communal areas and the residents are able to move freely within these areas. The communal areas are easily accessible for residents.</p> <p>Partial Provisional:</p> <p>There is adequate communal space available to accommodate the increase in hospital level 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>	<p>FA</p>	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and housekeeping staff seven days a week. Cleaning trolleys are kept in designated locked cupboards. Residents and family interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.</p> <p>Partial Provisional:</p> <p>Cleaning and laundry processes currently in place are adequate to accommodate the increase in number of hospital level residents.</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>Appropriate training, information, and equipment for responding to emergencies are provided. Fire evacuations are held six monthly. There is a minimum of one registered nurse or senior health care assistant (team leader) available 24 hours a day, seven days a week with a current first aid certificate.</p> <p>Civil defence and emergency policies and procedures are in place. A civil defence kit is readily accessible. An up to date register of all residents' details are held. There is an approved evacuation plan. The facility is well prepared for civil emergencies and has emergency lighting. A store of emergency water is kept. There are two gas BBQs</p>

		<p>for alternative cooking. Emergency food supplies are sufficient for three days. Extra blankets are available.</p> <p>There are batteries that can be used to operate electric beds in the event of a power failure. There is a list of names and contact details of staff so that they can easily be contacted in an emergency. At least three days stock of products such as incontinence products and personal protective equipment are stored at the facility.</p> <p>The electronic call bell system has recently been upgraded and is available in all areas. Residents were observed to have access to their call bells.</p> <p>Partial Provisional:</p> <p>Emergency and security systems are adequate to accommodate the proposed reconfiguration increase in hospital level residents.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.</p> <p>Residents and family interviewed confirm the facilities are maintained at an appropriate temperature.</p> <p>Partial Provisional:</p> <p>All areas in the facility allow for natural light, ventilation and heating, meeting requirements for the proposed reconfiguration of hospital level care.</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>Cairnfield has an established infection control (IC) programme that is appropriate for the size, complexity and degree of risk associated with the service. Policies and procedures document infection prevention and control surveillance methods. Surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. The data and trends are discussed at the monthly staff meetings (link 1.2.3.6). Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. A registered</p>

		nurse is the designated infection control nurse.
<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>	FA	There are adequate resources to implement the infection control programme at Cairnfield. The infection control (IC) nurse has attended infection control updates in the past 12 months. The infection control team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated at least annually.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The facility is committed to the on-going education of staff and residents. Education is facilitated by the infection control coordinator, who has completed training to ensure knowledge of current practice. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak had been resolved. Information is provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided to staff in 2015.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected, collated and analysed to identify areas for improvement or corrective action requirements. Trends are analysed and discussed at monthly staff meetings.</p> <p>Detailed information on the type of infections, treatment, duration of treatment and its effectiveness are recorded. Resident's infection trends/patterns are identified and recorded. Any corrective actions are</p>

		acted upon as sighted in the meeting minutes. A recent outbreak was well managed.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. Interviews with the care staff confirm their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had two hospital level residents using bed rails voluntarily as an enabler. Residents using an enabler undergo an assessment and consent process. Enabler use is reviewed three-monthly.</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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Five of fifteen accident/incident forms (for two residents with challenging behaviours and repeated falls) did not contain evidence that family were contacted. The clinical manager reports that these two families did not wish to be contacted but this was unable to be evidenced.	Five of fifteen accident/incident forms did not reflect evidence of open disclosure or evidence to substantiate why families were not kept informed.	<p>Ensure there is documented evidence to clearly substantiate instances where family do not wish to be kept informed.</p> <p>90 days</p>
<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>	PA Low	Quality and risk data (eg, accidents and incidents), are collected and collated each month. Missing was evidence of analysing accident and incident data to identify opportunities for improvements. An internal audit programme is in place but is not aligned to the audit schedule. Monthly	(i) An analysis of accident and incident data is missing. (ii) Internal audits are not being completed as per the audit schedule. (iii) There is a lack of documented evidence to reflect accident and incidents information being communicated to staff.	(i) Ensure an internal audit schedule is in place to guide the internal audit programme. (ii) Ensure accident and incident data that is collected and collated is also

		staff meetings do not reflect discussions around quality and risk management programme findings.		analysed. (iii) Ensure staff are informed of the findings. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	A corrective action form is completed when opportunities for improvements are identified. Corrective actions were not consistently signed off by management, to evidence implementation.	Corrective action forms are completed where opportunities for improvements are identified, but are not consistently signed off when implemented.	Ensure there is evidence of corrective actions being implemented. 90 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	Current staffing levels meet contractual requirements. An RN is scheduled to begin providing an additional 24 hours of cover (three days a week). This addition to staff is based on the current resident mix of 37 rest home level residents and 22 hospital level residents. It is unclear how staffing levels will be adjusted if more hospital level residents are admitted to the service. (The owner was not available during the audit and the facility manager did not have this information).	The staffing plan for the reconfiguration of 15 hospital beds does not identify staffing requirements based on the number of hospital beds occupied. The service has not determined how many more staff will need to be employed to cover the increase in hospital residents.	Ensure a staffing plan is developed to determine the number and skill mix of staff required as the number of hospital level residents increases. Ensure adequate staff are available to manage the increase in hospital residents. Prior to occupancy days
Criterion 1.2.9.10 All records pertaining to individual consumer service delivery are integrated.	PA Low	Information relating to family communication regarding resident's health status is held in a separate electronic file in the RN's computer.	Evidence of correspondence with families (eg, open disclosure) is stored in the clinical manager's computer without evidence of links in the residents' files.	Ensure resident's files are integrated. 90 days

<p>Criterion 1.2.9.7</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	PA Low	<p>Electronic data on the RN's computer, relating to family communication and open disclosure regarding residents' status has not been backed up, with several months of data reported as lost.</p>	<p>A robust back up system for electronic information has not been implemented.</p>	<p>Ensure a robust back up system is in place for all electronic information.</p> <p>90 days</p>
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	<p>The admission agreements are discussed with the resident/whanau/family on or before admission. Three of eight admission agreements (one hospital two rest home) were not signed by the resident/whanau/family within the required time frames.</p>	<p>One of eight resident (hospital) files sampled did not have an admission agreement.</p> <p>Two of eight residents (rest home) had admissions agreement on file that were not signed by the resident/whanau/family within 6 weeks of admission.</p>	<p>All residents are required to have signed admission agreements in place within the required time frames.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	<p>The service uses the robotic packed medication system. Medication reconciliation is completed on delivery of medications and the signing sheet is signed by the RN checking the medications. There are weekly and six monthly controlled drug checks. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Staff were observed administering medications. One resident was observed being given a bedtime medication at teatime.</p>	<p>(i) One resident was observed being given a bedtime medication at teatime.</p> <p>(ii) One of sixteen medications charts sampled had the sliding scale regime for insulin documented by the GP in the medication chart, rewritten (not signed or dated) on the top of a nursing diabetic management form used for the purposes of administering insulin.</p> <p>(iii) Three of sixteen medication charts did not have photo identification.</p>	<p>Ensure medication documentation and administration practices meet current legislative requirements and safe practice guidelines.</p> <p>30 days</p>
<p>Criterion 1.3.13.1</p>	PA	<p>There are seasonal menus on a four</p>	<p>(i) Two residents with food allergies did</p>	<p>(i) Ensure robust</p>

<p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>Moderate</p>	<p>week cycle. A dietitian review of the food menus over a period of two years has not been completed.</p> <p>The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or any other dietary requirements. Special diets, allergies and likes and dislikes are written in residents' profiles although two residents with food allergies did not have profiles available in the kitchen and staff were unaware. Moulded meals and nutritional supplements are available.</p>	<p>not have their profiles in the kitchen to alert kitchen staff. (ii) The menu has not been reviewed by a qualified dietitian in the last two years.</p>	<p>processes are in place to alert kitchen staff to residents' food allergies. (ii) Ensure a review of the menus is required by a qualified dietitian.</p> <p>60 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Low</p>	<p>All registered nurses are InterRAI competent. Files sampled included the InterRAI assessment tool. Assessments reviewed linked to the long term care plan (link 1.3.6.1). The files evidenced regular communication with families in the progress notes (link 1.1.9.1, 1.2.9.10). Families and residents interviewed advised they were informed about any change in health condition but were not involved in the development of the care plan.</p>	<p>There was no evidence of family or resident involvement in the development of the care plans in all eight files sampled.</p>	<p>All care plans have evidence of resident family/whanau involvement where possible and appropriate.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs,</p>	<p>PA Moderate</p>	<p>Assessments are completed on admission, when the care plan is reviewed and with a change in health condition. Three hospital and one rest home residents did not have interventions documented for all</p>	<p>1. The following documented shortfalls were identified around care plan documentation. (i) A hospital resident on morphine for severe pain had no documented pain assessments or pain management care plan. (ii) Two residents (one hospital, one rest home)</p>	<p>1. Ensure there are documented interventions to meet all identified care needs.</p> <p>2. Ensure that that all wound care</p>

<p>and desired outcomes.</p>		<p>identified care needs.</p> <p>The RN reviews information gathered through the use of monitoring charts to ensure interventions are documented in the care plans to reflect current care needs. Evaluation by an RN of information obtained through the use of monitoring charts was not evidenced for two residents with 24 hour behaviour monitoring charts.</p> <p>Wound assessments, treatment and evaluations were in place for one of three current wounds (one lesion, two skin tears) and one grade one pressure area. Adequate pressure management equipment and supplies were sighted.</p>	<p>with Type 2 diabetes and previous histories of hypoglycaemia had no emergency diabetic management interventions documented in their long term care plans (link rest home tracer). (iii) A hospital resident on warfarin identified as a medium falls risk had no interventions documented in the LTCP care plan to manage this risk. The interventions that were documented on the incident form following a fall were not transferred onto the short term care plan (link hospital tracer).</p> <p>2. Three of four wound care plans (two hospital, one rest home) had no on-going assessments of the wound or evaluations of wound care documented.</p> <p>3. Two hourly turns were not being documented for one hospital resident and one rest home resident.</p> <p>4. In two of eight files sampled observations noted on a behaviour monitoring chart were not reviewed by an RN for any change in care needs.</p>	<p>documentation complies with the Cairnfield House wound care management policy.</p> <p>3. Ensure that all monitoring forms are completed as directed in the care plan.</p> <p>4. Ensure that an RN reviews and evaluates all monitoring charts and if required, updates intervention for any change in care needs.</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>On admission an activities assessment is completed and an activities plan is developed.</p>	<p>Three of eight resident files sampled did not have a documented activity plan.</p>	<p>All residents have a documented activities plan.</p> <p>90 days</p>

<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>The RN described evaluating information obtained through the use of assessment tools, progress notes and short term care plans to ensure interventions are documented in the care plans to reflect current care needs. Review of care plans identified interventions for changes in care needs were not always documented. Care plan evaluations are completed six monthly but not all changes identified through evaluations were updated in the care plan.</p>	<p>1. In three of eight files sampled, the LTCP was not updated with a change in care needs.</p> <p>(i) One hospital resident with an indwelling catheter (IDC) did not have an IDC management plan documented.</p> <p>(ii) One palliative care resident had an end of life care plan documented in the progress notes that was not transferred to the end of life care plan.</p> <p>(iii) Short term care needs in two of eight files sampled, were not transferred to the long term care plan, (eg, one hospital resident with frequent urinary tract infections and one hospital resident with challenging behaviours).</p> <p>2. In two of eight files sampled, interventions identified in the evaluations were not transferred to the long term care plan for;</p> <p>(i) One hospital resident's mobility care plan evaluation stated the resident is bed bound and cannot walk and the long term care plan advised the resident walks around the building.</p> <p>(ii) The hygiene care plan evaluation stated two person assist and the long term care plan stated one person assist.</p>	<p>Ensure care plans are updated to reflect changes in health status.</p> <p>60 days</p>
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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.