# St Patrick's Home and Hospital Limited - St Patrick's Home and Hospital

## Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services 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:** St Patrick's Home and Hospital Limited

**Premises audited:** St Patrick's Home and Hospital

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

**Dates of audit:** Start date: 3 March 2016 End date: 4 March 2016

**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:** 49

# 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 |
|  | 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

St Patrick's Home and Hospital can provide care for up to 60 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The manager is responsible for the overall management of the facility including clinical care and is supported by the assistant manager and two directors. Service delivery is monitored.

Improvements are required to the following: informing family member after an incident or accident, informed consent, complaints management, the quality programme, training; safety for residents; documentation of care; and medication management.

## 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 medium or high risk and/or unattained and of low risk. |

Staff are informed of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service. Some information for residents and family members is accessible. Residents and family members confirm their rights are met, staff are respectful of their needs and communication is appropriate.

The manager is responsible for management of complaints. Complaints documented on the complaints register are managed as per timeframes in the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

Improvements are required to ensuring that family are informed of any incident involving their family member, consent for transport, advance directives, information around advocacy services and documentation of verbal complaints on the complaints register.

## Organisational management

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

St Patrick's Home and Hospital has a documented quality and risk management system. There is a management system to manage residents’ records with a document control process in place.

There are human resource policies implemented around recruitment, selection and orientation. Staffing is rostered to meet numbers of residents in the facility and acuity levels. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

Improvements are required to the quality and risk management programme including review of policies, documentation of meeting minutes, resolution of issues, incident and accident management and training for staff.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents receive services from suitably experienced staff. Residents and family members have opportunity to contribute to care plans.

Residents’ files reviewed demonstrated risk assessments, interRAI assessments, initial care plans and long term care plans are not consistently conducted within the required timeframes. Care plan interventions and coordination of clinical services require improvement.

Activities are planned and the programme is available to residents. Residents’ interviews confirm satisfaction with the activities provided.

There are appropriate medicines management processes for prescribing, administration, medication reconciliation, dispensing, storage and disposal of medicines, however there is an opportunity for improvement relating to some aspects of medication management and staff competencies. At the time of the audit the service did not have any residents who self-administered medicines.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines and menus are reviewed by a dietitian.

## Safe and appropriate environment

|  |  |  |
| --- | --- | --- |
| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Some standards applicable to this service partially attained and of low risk. |

There is a current building warrant of fitness and New Zealand Fire Service evacuation scheme in place. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

An improvement is required to ensuring that windows are safe for residents.

## 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. |

The approval process for enabler use will be activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were no residents using restraint or requiring enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour has been provided.

## 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. |

The infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. New employees are provided with training in infection control practices and infection control education is available for all staff. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided.

## 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 | 4 | 7 | 0 | 0 |
| **Criteria** | 0 | 78 | 0 | 5 | 10 | 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](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).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Residents state that they receive services that meet their cultural needs and they receive information relative to their needs. They state that staff respect their wishes.  Staff are orientated on residents’ rights when employed by the organisation. Staff were able to explain rights for residents in a way that promotes choice.  The posters identifying residents’ rights are displayed in the facility.  Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the education programme with this provided in 2013 (refer 1.2.7).  Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.  The auditors noted respectful attitudes towards residents on the days of the audit. |
| 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 Moderate | There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent however this should be updated to include consent for transporting of residents (refer 1.2.3.6). Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.  All resident files identified that informed consent is collected as part of the admission agreement apart from documentation of consent for transporting of residents. Interviews with staff confirmed their understanding of informed consent processes.  The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families during the admission process. .  The policy and procedure includes guidelines for consent for resuscitation/advance directives. An improvement is required to the policy around advance directives (refer 1.2.3.6) and documentation of advanced directives. . |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Staff state that written information on the role of advocacy services is provided to residents at the time of entry to the service. Resident information around advocacy services is described as being available at the entrance to the service and in information packs provided to residents and family on admission to the service.  Staff training on the role of advocacy services is included in training on The Code and this was last provided for staff in 2013.  The Health and Disability advocate visits the service during the year as confirmed by the management team.  Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked.  Families interviewed confirm they could visit at any time and are always made to feel welcome.  Residents are encouraged to be involved in community activities and to maintain family and friends networks. Residents' files reviewed demonstrate that progress notes and the content of care plans include regular outings and appointments with a van able to take residents into the community. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The organisation’s complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; the outcome and agreed action.  The complaints register does not include documentation of verbal complaints and an improvement is required. Evidence relating to each lodged complaint is held in the complaints folder. A complaint reviewed in 2014 indicates that the complaint is investigated promptly with the issues resolved in a timely manner.  The manager is responsible for managing complaints and residents and family state that these are dealt with as soon as they are identified.  There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The manager or a registered nurse discusses the Code, including the complaints process with residents and their family, on admission. Discussions relating to the Code can also be held at the resident meetings. Residents and family interviews confirm their rights are being upheld by the service. The information pack includes reference to the poster of the Code displayed in the dining room. . Information around rights can be produced in a bigger font, if required.  Information is given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members are able to describe their rights and advocacy services particularly in relation to the complaints process. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents’ support needs are assessed using a holistic approach. The initial and on-going assessments gain details of people’s beliefs and values, with care plans completed with the resident and family member. Interventions to support these are identified and evaluated.  A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.  The service ensures that each resident has the right to privacy and dignity. The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room and there are areas in the facility which can be used for private meetings.  Health care assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families confirm that residents’ privacy is respected.  The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports for 2015 or on the incidents reviewed in residents’ files. Residents, staff, family and the general practitioner confirm that there is no evidence of abuse or neglect. Staff interviewed were aware of the need for them to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.  Resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The organisation has a cultural policy which outlines the processes for working with people from other cultures. The rights of the residents/family to practise their own beliefs are acknowledged in the policies documented.  There are two external support people who can provide advice for staff and Māori residents if required. One is a church minister who visits the service weekly. Staff report that specific cultural needs are identified in the residents’ care plans.  Staff are aware of the importance of family/whānau in the delivery of care for the Māori residents. Staff have had training around cultural rights, safety and Māori in 2015. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies each resident’s personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and choices in meals and activities. Staff work to balance service delivery, duty of care and resident choice.  Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident’s cultural values and beliefs. This information is used to develop a care plan.  Staff are familiar with how translating and interpreting services can be accessed. There are residents in the service for whom English is a second language. The service has employed staff who can speak their language and family are actively engaged in their care. Residents who cannot speak English have a list of words that are interpreted for staff to use when supporting the resident with cares. Two residents interviewed who do not speak English state that they are very happy with the care and treatment provided and state that they enjoy having staff who speak their language on the morning and afternoon shifts. A staff member interviewed who can speak with these residents states that they are allocated the residents on the shift so that they can converse with the resident. The service has employed an Asian cook who is able to provide Asian food for residents. The residents interviewed stated that while the food is not exactly the same as in their culture, they appreciate the food provided for them. . |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The facility implements policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Staff interviewed state that they are aware of the policies and are active in identifying any issues that relate to the policy.  Residents and family state that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination.  Job descriptions include responsibilities of the position and an outline of expectations with a job description sighted in staff files reviewed relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the health care assistants’ role and responsibilities. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | St Patrick's Home and Hospital implements policies to guide practice (refer 1.2.3.3). A quality framework supports an internal audit programme (refer 1.2.3.3, 1.2.3.6 and 1.2.3.8).  There is a training programme for all staff and registered nurses are encouraged to complete training provided by the district health board (refer 1.2.7.5).  Residents and families interviewed expressed a high level of satisfaction with the care delivered. The level of satisfaction was also expressed in annual satisfaction surveys. . The general practitioner interviewed expressed satisfaction with the clinical oversight and care provided.  Consultation is available through the organisation’s management team that includes the manager, directors and the assistant manager. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed in some cases if the resident has an incident, accident or has a change in health or a change in needs, as evidenced in completed accident/incident forms. An improvement is required to documentation that family are informed.  Family contact is recorded in residents’ files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and could attend the resident meetings.  Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. Those reviewed are signed on the day of admission.  Interpreting services are available through the district health board and family interpret for resident who require this in the service. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Two directors provide oversight of the service. Both were on site during the audit. One takes responsibility for the financial and building component of the service and the other for care and resident requirements. One director was an enrolled nurse (does not have a current practicing certificate) and the other has a bachelor in counselling.  The manager (previously the clinical manager) is a registered nurse with a current practising certificate. The manager joined St Patrick's in 2011 and is currently completing a Masters in Nursing.  There is a philosophy, values and goals documented in the strategic overview of the service. The strategic plan also includes a marketing plan and SWOT analysis. These are communicated to residents, staff and family through information in booklets and in staff orientation.  The facility can provide care for up to 60 residents with eight designated bedrooms for rest home level of care. Other bedrooms are designated as dual purpose beds (hospital and rest home). During the audit there were 49 residents living at the facility including 19 residents requiring rest home level of care and 30 residents requiring hospital level of care. One resident was identified as having a long term chronic condition. |
| Standard 1.2.2: Service Management  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. | FA | In the absence of the manager, the assistant manager and a senior registered nurse is in charge with support from the directors. The assistant manager and senior nurse are clearly able to articulate and fulfil the management role, and are aware of limitations to scope of practice. |
| 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 Moderate | St Patrick's Home and Hospital uses the quality and risk management framework that is documented to guide practice.  The service implements organisational policies and procedures to support service delivery. All policies are expected to be reviewed two yearly. An improvement is required to review of policies and procedures. Policies are readily available to staff in hard copy however the policies in hard copy do not include recently reviewed policies. The policy around pressure injuries has been updated.  Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed in some cases. Graphs of incidents are completed monthly. Monthly meeting minutes including management, staff, registered nurse and health and safety meetings with monthly resident meetings. Family are able to attend the resident meetings if they wish. Staff report that they are kept informed of quality improvements. Improvements are required to evidence of discussion of data at meetings and documentation of resolution of issues.  The satisfaction survey for family and residents in 2015 shows a high level of satisfaction and this was confirmed by residents and family interviewed.  The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. |
| 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. | PA Moderate | The manager is aware of situations in which the service would need to report and notify statutory authorities, including, police attending the facility, unexpected deaths, sentinel events, notification of a pressure injury, infectious disease outbreaks and changes in key managers. The Ministry of Health and district health board have been notified of any sentinel events and of changes in management roles.  Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and are able to describe the importance of recording near misses.  Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. |
| 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. | PA Low | The registered nurses and the manager hold current annual practising certificates along with other health practitioners involved with the service.  Staff files contain appointment documentation including: signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.  All staff complete an orientation programme and health care assistants (HCAs) are paired with a senior HCA for shifts or until they demonstrate competency on a number of tasks including personal cares. HCAs confirm their role in supporting and buddying new staff. A new staff member interviewed confirmed that they had completed an orientation programme.  The organisation has an annual education and training programme. Staff attendances are documented for internal training with evidence that there is good attendance at training sessions. Registered nurses attend training provided by the district health board. The pharmacy provides training annually around medication administration and management. Education and training hours are at least eight hours a year for each staff member. Some training is completed three yearly and an improvement is required.  Three of the six registered nurses (including the manager) have completed interRAI training and two other registered nurses are currently completing the training. Staff have completed training around pressure injuries (PIs) in 2013, 2014 and 2016. Registered nurses have attended specific training around PIs in 2014 facilitated by the district health board.  Some training is completed three yearly and an improvement is required. |
| 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 staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.  There are 42 staff, including clinical staff, staff who facilitate the activities programme and household staff. There is always a registered nurse (RN) on each shift. The manager (RN) and assistant manager are on call. If the manager is on leave, a senior RN takes the on call role.  There are four units downstairs and a house that has rooms for residents. A staff member is always allocated to support these residents on morning and afternoon shifts and staff complete checks at least three times during the night.  Residents and families interviewed confirm staffing is adequate to meet the residents’ needs. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.  There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner.  Entries are legible. Entries are dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including their designation.  Resident files are protected from unauthorised access by being locked away in an office.  Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Staff state that they read the long term plans at the beginning of each shift and are informed of any changes through the handover process. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry and assessment processes are recorded and implemented. Interview with a director confirmed they receive enquiries about the service from prospective residents and their families. The manager/registered nurse (RN) obtains relevant clinical information of the prospective resident and their suitability for admission to the facility.  The facility information pack is available for residents and their family and contains all relevant information.  The admission agreements evidence residents and/or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. The needs assessments are completed for rest home and hospital level of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and coordinated manner. Management interview confirmed there is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. There was evidence of relevant records in the residents’ files for residents who have been transferred to and from the facility. |
| 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. | PA Moderate | A safe system of medicine administration was observed on the days of audit. The staff observed demonstrated knowledge and understanding of their roles and responsibilities related to medicine management. Not all staff who administer medicines have current medication competencies. There is no recorded evidence the medicines are checked upon arrival at the facility.  Medication and controlled drugs are safety stored. The controlled drug register evidences weekly checks and six monthly stock takes.  The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.  The GPs signature and date are recorded on the commencement and discontinuation of medicines. GP three monthly medication reviews are conducted and recorded on the medication charts and allergies are noted. The residents’ photos on medication charts do not record the date of photos taken.  The manager stated there were no residents who self-administer medicines on audit days. The policy on self-administration of medicines does not comply with guidelines (refer to 1.2.3). |
| 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. | FA | There is a seasonal menu that has been reviewed by a dietitian. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Dietary profiles are located in the residents’ files and copies are provided to kitchen staff. The personal food preferences of the residents, special diets and modified nutritional requirements are communicated to the kitchen staff and accommodated in the menu. . Residents’ weights are monitored monthly or more frequently when this is required.  Evidence of resident satisfaction with meals is verified by resident and family/whānau interviews and resident meeting minutes.  There is sufficient staff on duty in the dining room at meal times to ensure appropriate assistance is available to residents, as needed.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | Interviews with the manager/RN and the assistant manager verified a process exists for informing residents, their family/whānau and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | The Needs Assessment and Service Coordination (NASC) agency; other service providers involved with the resident; the resident; family/whānau and on-site assessments tools are available for the RNs to use and complete the resident’s assessment on admission, however these are not always utilised for the initial care planning process. Staff and residents state assessments take place in the privacy of the resident’s bedroom with the resident and/or family/whānau present, if requested. .  The interRAI assessment is not consistently completed within the required timeframes post admission (refer to 1.3.3). |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The residents’ long term care plans are individualised and integrated. The long term care plan interventions reflect the risk assessments and the level of care required (refer to 1.3.6). Short term care plans are developed, when required and signed off by the RN when problems are resolved. The residents and family have input into their care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Care plan interventions are not consistently updated to reflect assessment findings or the assessments are not completed when required (refer to 1.3.4). Residents and family/whānau members expressed satisfaction with the care provided.  There were sufficient supplies of equipment seen to be available that comply with best practice guidelines and meet the residents’ needs (refer to hospital tracer methodology). |
| 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 | The service employs an activities coordinator, an occupational therapist and a physiotherapist. Interviews with the activities coordinator and the occupational therapist confirm assessments are completed for residents on admission relating to social, recreational and rehabilitation needs (refer to 1.3.3.). Physiotherapist interview confirmed residents are assessed for mobility needs and assisted with group and personalised exercise programmes. Residents’ participation in individual exercise programmes was evidenced on audit days.  Residents’ activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. The activities reflect ordinary patterns of life and include normal community activities.  Residents’ meeting minutes evidence discussion relating to activities (refer to 1.2.3). Interviews with residents and family verify satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated and reported in the progress notes (refer to 1.3.4). Formal care plan evaluations occur every six months or as residents’ needs change and are carried out by the RN.  A short term care plan is initiated for short term concerns. Interviews, verified residents and family/whānau are included and informed of changes. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP sends a referral to seek specialist service provider assistance. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage.  Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.  There is provision and availability of protective clothing and equipment that is appropriate to the recognised risks, for example: goggles/visors; gloves; aprons; footwear; and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high risk areas. |
| 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 | A current building warrant of fitness is displayed – expiry date August 2016. There have been no building modifications since the last audit although there has been refurbishment of rooms.  There is a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment annually.  Interviews with staff and observation of the facility confirm there is adequate equipment.  There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy when required. There are decks and grass areas with shade, seating and outdoor tables.  An improvement is required to ensure that windows are safe for residents. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.  Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.  Residents and family members report that there are sufficient toilets and showers with some rooms in the rest home/hospital area having their own en-suite.  Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. In rooms requiring equipment there is sufficient space for both the equipment, for example, hoists, at least two staff and the resident, with the ability to include emergency equipment in the room, if required.  Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.  There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has a lounge/dining area and other areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.  The dining area has ample space for residents. Residents can choose to have their meals in their room. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry is completed on site, with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry. Laundry staff are required to return linen to the rooms. Residents and family members state that the laundry is managed. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.  There are cleaners on site during the day, five days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed to be vigilant on the days of the audit around keeping the trolley in sight.  All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.  Cleaners and laundry staff state that they receive monthly training from the company that provides chemicals. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | An evacuation plan was approved by the New Zealand Fire Service in July 2014. An evacuation policy on emergency and security situations is in place. A fire drill is provided to staff, six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.  There is always at least one staff member with a first aid certificate on duty with most staff having completed first aid training.  All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.  A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency, including food, water, blankets, emergency lighting and gas BBQs.  An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas, including the hallways and dining rooms. Call bells are monitored to ensure that they are answered promptly and that all are operational. Residents and family state that there are prompt responses to call bells.  The doors are locked in the evenings. Staff complete a check in the evening that confirms that security measures have been put in place. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | 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, heating and an environment that is maintained at a safe and comfortable temperature.  There is a designated external smoking area for residents.  Family and residents confirm that rooms are maintained at an appropriate temperature. |
| Standard 3.1: Infection control management  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. | FA | The infection control (IC) policy and procedures provide information and resources to inform staff on infection prevention and control (refer to 1.2.3).  The delegation of IC matters is documented in policies, along with an infection control coordinator’s (ICC) job description. The ICC is a RN. There is evidence of regular reports on infection related issues and these are at times communicated to staff and management (refer to 1.2.3). The IC programme was reviewed in 2015. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has access to relevant and current information which is appropriate to the size and complexity of the service. The staff observed at the audit, demonstrated IC practices that are in line with the requirements of the IC standard. |
| Standard 3.3: Policies and procedures  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. | FA | The IC policies and procedures are written in a user friendly format (refer to 1.2.3). The IC policies and procedure are reviewed by the manager /RN. IC policies and procedures identify links to other documentation in the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control education is provided to staff, as part of their orientation and as part of the internal education (refer to 1.2.7). The IC staff education is provided by the ICC and external specialists. The ICC has completed an external education in IC in 2015. |
| 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 | The infection control coordinator is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example, facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.  Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented.   The organisation has an internal benchmarking system. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meeting.  The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents’ files evidenced the residents’ who were diagnosed with an infection had short term care plans and the infection were entered on the infection log.  The ICC/ RN is responsible for the surveillance programme. Surveillance analysis is completed and reported at some meetings (refer to 1.2.3). In interview, the manager/ RN confirmed no outbreak occurred at the facility since last audit.  In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers and short term care plans. This was evidenced during attendance at the staff handover and review of the residents’ files. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There were no residents at the facility using enablers or restraint on days of audit. Education around restraint minimisation was last conducted in June 2014 (refer to 1.2.7).  The restraint policy requires review to be in line with the restraint minimisation and safe practice standard (refer to 1.2.3). |

# 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 Moderate | The resident signs an agreement on entry to the service. This includes consent for treatment, photographs and identifies next of kin. Consent for transport is not documented in the agreement.  The policy indicates that the general practitioner can make an advance directive on behalf of the resident. The policy and form do not adequately provide guidelines for documentation of competency of the resident to make an advance directive or of the approach in New Zealand for residents not deemed competent. | Residents do not sign to give consent for transport.  Eight of eight files reviewed did not include documentation around competency of a resident to make an advance directive around resuscitation or not for resuscitation.  The doctor has signed an advance directive form that indicates if the resident is or is not for resuscitation, whether the resident should be transferred to hospital for life sustaining treatment and whether antibiotics should or should not be used. All files included sign off by the doctor. | Document consent for transport for each resident.  Document competency of the resident to make an advance directive.  Ensure that advance directives are signed only by the resident deemed competent to make the decision.  90 days |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | There is a complaints register which records written complaints. The last complaint is documented as being received in 2014 and the manager confirms that there have not been any written complaints since this time.  Verbal complaints are documented in the communications book only. | Verbal complaints are not recorded on the complaints register. | Ensure that verbal complaints are documented on the complaints register with evidence of actions taken to resolve these.  180 days |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Incident forms include the ability to document whether a family member has been informed after an incident, accident or change in needs. Five of ten files reviewed indicated that the family had been informed of an incident. | Five of ten files did not include documentation that the family had been informed of an incident/accident. | Document that family have been informed if their family member has had an incident or accident.  90 days |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Moderate | Policies are expected to be reviewed two yearly. Some have been reviewed, however, some policies have not been reviewed and do not meet best or evidence based guidelines.  Hard copy versions of the policies are available for staff, however, recently reviewed policies are not printed.  There are at times, two versions of policies available to staff. | Policies have not been reviewed, two yearly, as required in policy.  Hard copy manuals of policies are not up to date.  At times, there are two versions of the same policy available to staff. | Review policies at least two yearly as scheduled and ensure that policies reflect legislation and best and evidence based guidelines.  Keep up to date policy manuals available for staff.  Ensure that the most recent version of the policy is available for staff.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | There are staff, health and safety, registered nurse and management meetings. Minutes are kept of all the monthly meetings, however, there is limited documentation of discussion. | Meeting minutes do not evidence robust discussion particularly of clinical aspects of the service including discussion of pressure injuries, tabling of graphs of incidents documented on a monthly basis and review of falls from a clinical perspective. | Ensure that meeting minutes reflect robust discussion of service delivery at all levels within the service.  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 Moderate | Internal audits, meeting minutes and other data collected identities issues and areas for improvement. Corrective action plans are documented. | Evidence of resolution of issues is not always documented. | Document evidence of resolution of issues.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Incident forms are documented, and at times these include documentation of observations and sign off by the manager, indicating review of the incidents.  The manager graphs the incidents on a monthly basis to review for trends. The graph is placed on the notice board for staff to review. | Seven of ten incident forms did not include documentation of observations taken or if recorded, these were only taken once after the incident/accident.  Four of ten incident forms were not signed off by the manager to indicate that they had been reviewed. | i) Ensure that incident forms include documentation of observations taken with these taken for a period of time to determine health of the resident.  ii) Ensure that incident forms are signed off by the manager to indicate that they have been reviewed.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Staff have completed training that includes clinical aspects of care. Topics have included continence, personal cares, stoma care, pressure injuries and Parkinson’s disease.  Some training is provided up to three yearly. While there is a stable staff, there are also new staff in the service who have not received training around some topics in the past year. This includes training for restraint, abuse and neglect, rights and advocacy. . | A comprehensive training plan is not provided annually for staff. | Ensure that a comprehensive training plan is provided annually for staff.  180 days |
| Criterion 1.3.12.1  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. | PA Low | The assistant manager interview confirmed that the medicines are checked against the medicine chart on arrival at the facility, however there is no recorded evidence of this maintained at the facility.  The medication files evidence residents’ photos, however these are not dated to identify residents and ensure they resemble their current appearance. | i) Residents’ photos on medication charts do not record when the photos were taken.  ii) There is no record of medication checks when medications arrive at the facility. | i) Provide evidence the residents’ photos on medication charts are dated  ii) Provide recorded evidence of the medicines being checked when they arrive at the facility.  90 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Staff have attended in service education in medication management provided by a pharmacist in April 2015. There are four RNs who have completed certificate of completion (training) in intravenous (IV) cannulation in May 2015.  The medication competency assessment consists of visual observations of the staff member administering medicines. There is no recorded evidence of a written medication competency test.  Eight staff files reviewed evidenced four staff who administer medicines do not have current medication competencies, and the remaining four staff have medication observation competencies only. One HCA interviewed stated they administer medication. This staff member’s medication competency was also reviewed and evidenced out of date medication competency. | Not all staff who administer medicines have current medication competencies. | Provide evidence that all staff who administer medicines have current medication competencies.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Review of the residents’ clinical files evidenced: the initial assessments are not consistently completed; the initial care plans are not dated and signed by the person completing the initial care plan; the long term care plans are not consistently completed within the three week period post admission; the interRAI assessments are not consistently completed within the required three week period post admission and the risk assessments are not reviewed when required. | The time frames for service delivery are not adhered to consistently. | Provide evidence each stage of service provision is provided within the required timeframes.  60 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | The staff handovers are conducted at the beginning of each shift. Medical progress notes are current, with GP progress note entry recorded each time the resident is reviewed by the GP.  Management and clinical staff interviews stated there were no residents with PI. On first day of audit, via a family interview, the audit team was alerted to a resident with PI. There was some reference to the PI in the resident’s progress notes. There was no documentation relating to: family being notified of the PI, even though this had occurred as stated by the family member (refer to 1.1.9); completion of an accident/ incident form (refer to 1.2.4); PI management plan (refer to 1.3.6); discussion in the meeting minutes relating to the PI (refer to 1.2.3).  Review of the residents’ clinical files evidenced the progress notes are at times entered in daily. There were number of progress notes with two to four days of no entries. The frequency of RN entries were up to once a month. Not all residents’ relevant issues were communicated via progress notes. | The service is not coordinated to promote continuity in service delivery. | Provide evidence of a coordinated service in the delivery of clinical care.  60 days |
| Criterion 1.3.4.2  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. | PA Moderate | The assessments are not consistently completed on admission (refer to 1.3.3.). The initial assessment/initial care plan is a one page form that does not consistently record all the required needs of the residents. Three of the eight initial care plans were incomplete. | Assessment processes do not consistently identify all the needs, outcomes and/ or goals of the residents in the initial care plans. | Provide evidence the assessment processes identify all the residents’ needs, outcomes and/ or goals.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Assessments are not reviewed consistently when required (refer to 1.3.3). The required needs of residents’ are not consistently recorded on the long term care plan and the interventions to the needs are not recorded. | Care plan interventions do not consistently contribute to meeting residents’ needs. | Ensure all care needs are recorded on the long term care plan and interventions relating to the identified needs contribute to meeting the residents’ needs.  60 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | Most windows have stays that prevent the windows from opening wide. Some windows, including bedroom windows, open fully and potentially this could be a hazard. Some windows also open fully onto deck areas and again could be a hazard. There have no incidents documented where the open windows have caused an adverse event. | Some windows in the bedrooms open widely with a one storey drop. | Ensure that windows are safe for residents.  60 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.

|  |
| --- |
| No data to display |

End of the report.