Warkworth Hospital Limited - Warkworth Hospital

Introduction

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

The audit has been conducted by Health Audit (NZ) 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:	Warkworth Hospital Limited
Premises audited:	Warkworth Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 January 2017 End date: 23 January 2017

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: 32

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Warkworth Hospital Limited is the governing body and is responsible for the services provided at Warkworth Hospital. It provides rest home and hospital care for up to 36 residents.

This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the provider's contract with the district health board (DHB). The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family/whanau, management and staff. The general practitioner (GP) was not available.

There were nine areas identified for improvement in the previous certification audit. Six are now fully attained and whilst progress is being made in three areas related to evaluating corrective actions, care planning documentation and medication management remain open. Three new areas were identified for improvement in this audit related to policies and procedures, staff education and annual appraisals and medication competencies.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

Residents confirm they are treated with respect and that privacy is maintained. Services are provided in a manner that meets residents' rights and acknowledges cultural and individual values and beliefs. Interpreter services are used when required. The sharing of information with residents and family/whānau is documented.

The service has a complaints management system in place which meets the standard and legislative requirements. At the time of audit there were no outstanding complaints.

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.

Warkworth Hospital strategic planning is undertaken by the directors with input from the nurse manager and the operations manager. The mission statement and purpose of the business is documented.

Day to day operations are the responsibility of the nurse manager and the operations manager. Both are suitably experienced for the roles they undertake and are supported by a team of 11 registered nurses (RNs), caregivers and auxiliary staff.

There is a documented quality and risk management system that supports the provision of clinical care. Quality and risk data is recorded and shared with staff and management. This process is overseen by the nurse manager. Data collected covers the key components of service delivery and includes event reporting, complaints management, infection control, health and safety and restraint minimisation. The annual audit programme is up to date. Corrective action planning is implemented to manage any areas of concern or deficits.

The adverse event reporting system complies with policy and staff document and report adverse, unplanned or untoward events.

Human resources practices are implemented. The staffing skill mix is appropriate for the level of care and services provided. Every shift is covered by a registered nurse and at least one staff member who has a current first aid certificate.

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.

The residents and family report satisfaction with the quality of service delivery. The assessments, review and evaluation of the care plans are conducted within the required time frames. The resident, and where appropriate their family/whānau, are involved in the development and review of the care plans. The interventions delivered are appropriate to the needs of the residents.

Planned activities are individualised to ensure each resident participates in meaningful activities. There are specific programmes to meet the needs of the residents, including the younger residents.

Safe medication administration procedures were observed. Medications are stored securely.

Food services meet best practice requirements. The menu has been reviewed by a dietitian as suitable for residents. Special dietary needs are catered for.

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.

Warkworth Hospital has a current building warrant of fitness.

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 service has a commitment to the minimising and appropriate use of restraints/enablers. Restraint and enablers are only used as a last resort to maintain the resident's safety and comfort. Clear definitions in policies ensure that staff understand the implication of restraint and enabler use. There were no restraints in use and one resident with a bed rail as an enabler.

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 management system includes surveillance and is appropriate for the nature of the service. The infection control coordinator collates monthly surveillance data. Where there are any trends identified, actions are implemented. Infection control surveillance data is reported at management and staff meetings. The infection control programme was reviewed in March 2016.

Expertise is available and can be sought as required.

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	14	0	2	2	0	0
Criteria	0	35	0	3	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy meets Right 10 of the Code. Complaints management is implemented as per policy requirements. The complaints register was current and identified that there were no open complaints at the time of the audit. Management operate an open door system to ensure they are available to speak to family/whanau or residents in the event a concern is raised. The nurse manager confirmed that complaints are used as an opportunity to improve services as required (refer standard 1.2.3 regarding the corrective action process). Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a standing agenda item for staff and RN meetings Complaints processes are explained during the admission process as confirmed during resident and family/whānau interviews. Complaints forms are easily accessible from the reception area and there is a suggestion box which is cleared daily. There have been no complaints to externally bodies since the previous audit. All complaints have been resolved in-house.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	The service is able to demonstrate that residents' privacy, dignity and independence is maintained. There are two double bedrooms which have privacy curtains and staff verbalised how auditory privacy is maintained. The previous corrective action regarding a disruptive resident was solved when the resident was moved to higher level of care.

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		Resident and family/whanau confirmed they had no issues with privacy and that staff respect their needs.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	As identified in policy, the service ensures that full and frank information is shared with residents and family/whānau as appropriate. Information sharing was identified in the residents' files sampled. Incident and accident forms also identify that family/whanau are notified where appropriate. Management confirmed that interpreters would be used as required to ensure residents and family/whānau have a full understanding of issues discussed. At the time of audit, the nurse manager confirmed there are no residents with English as a second language. Family/whanau and residents confirmed that they are kept well informed of any issues. Resident files contained evidence of family/whanau input into care planning.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The facility can provide care for up to 36 residents with 32 beds occupied on the day of audit consisting of six rest home level care and 26 hospital level care residents. One hospital level care resident is under the age of 65 years. Ten of the 36 beds are dual purpose and can be used for either rest home or hospital level care. The organisations mission statement and purpose are documented. The nurse manager stated that strategic planning is undertaken at a governance level each year. Risk management processes are reviewed annually by the company directors with input from the nurse manager and the operations manager. Annual goals are documented at this time. Day to day operations are overseen by the two managers. The nurse manager holds a current annual practising certificate and has been in the role for 10 years. The nurse manager is assisted by the operations manager who has previous health experience and has been in the role for eight years. The directors visit the facility every two weeks and are available via telephone if required. Members of the management team attend the required hours of education and training covering clinical and management topics and are supported by a team of 11 registered nurses, three of whom are interRAI competent. Interviews with residents and family/whānau members confirmed they can speak with a member of the management team when they wish. No negative comments were made regarding services provided.
Standard 1.2.3: Quality And Risk Management Systems	PA Low	There is a documented quality and risk management system. Policies and procedures are available to guide staff actions. Legislative changes are covered by documentation such as the updated need for reporting pressure injuries to the Ministry of Health, however not all policies have been reviewed within the required

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		time frames and an improvement is required. There is an archive system in place for obsolete documents. Progress toward business and quality goals set for 2016 are reported to the directors. Quality data for incident and accidents, complaints, infection control, health and safety, internal audits and restraint are collated, trended, reviewed and corrective actions developed if any deficits are noted. Documented quality information is available to all staff and they report during interview that are made aware of all corrective actions. This addresses the previous area of improvement regarding the collation and communication of quality data. The previous finding regarding internal audits has also been addressed. Regular internal audits now cover all aspects of service delivery and are kept up date, however further work is still required on completing the corrective action process related to policies and procedures. Actual and potential risks are identified and documented in the hazard register and in the risk management plan. Newly found hazards and risks are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The nurse manager and the operations manager confirmed their understanding regarding their obligations in relation to essential notification requirements including pressure injury reporting under Section 31 of the Health and Disability Services (Safety) Act 2001. Policy is implemented in relation to reporting, recording and monitoring adverse events. The service records all incidents and accidents. Any follow up required is undertaken in a timely manner and outcomes are monitored by management. Staff interviewed confirmed they report and record all incidents and accidents. Documentation confirmed that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. Documentation identifies that family/whanau are informed of any concerns or incidents that occur and this was supported during interviews undertaken.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance	PA Low	Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in staff files sampled. Policies and procedures identify employment practice; reflect good practice and meet legislative requirements are implemented. Job descriptions describe staff responsibilities and accountabilities. Staff files sampled confirmed that staff have completed an orientation programme appropriate to their role. The

with good employment practice and meet the requirements of legislation.		previous area of improvement regarding restraint competencies has been addressed, however not medication competencies are up to date and an improvement has been documented in criterion 1.3.12.3. There is an annual education calendar for on-site education. This covers all aspects related to care provision. Education included guest speakers such as the gerontology nurse from Auckland District Health Board, mental health services, Health and Disability representative, the district nurse (wound care specialist) and chemical provider. Staff are informed of off-site education and have attended first aid and hospice education. Registered nurses are encouraged to undertake Ministry of Health and other relevant on-line education. They are aware of the need to meet the education hours set down by the nursing council. Resident and family/whānau members interviewed reported that residents' needs are met by the service in a professional manner. An improvement is required regarding training records and performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Policy related to staff skill mixes and experience is reflected in the roster to meet and exceed contractual requirements. Every shift is covered by at least one RN and adequate numbers of caregivers for each shift. All RNs hold current first aid certificates. The rosters sighted, and staff interviews confirmed, that staff are replaced for sick leave or annual leave. Staff stated they have enough time to complete all tasks. This is supported in resident and family/whanau interviews. The nurse manager and operations manager work Monday to Friday. There are dedicated kitchen, cleaning and laundry staff seven days a week. Activities staff work Monday to Friday.
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	Previous audit identified four areas for improvement related to medication management. Three of these have now been fully addressed. There was evidence sighted through the observation of the medication round and sampling of 10 medication charts that the correct medication administration procedure was followed. The indication for use of 'as required' medications is recorded and a specimen register is maintained of the nursing and medical personnel. However, transcribing was still evidenced in the medication charts sampled and there is a new area for improvement related to the documentation of staff medication competencies. Mediations are administered from a pharmacy pre-packed system. The service uses a national long term paper based medication chart. All medication charts sampled are reviewed as required and discontinued medications are signed and dated by the GP. Allergies are clearly documented. Medication charts are legibly written and the health care assistant was observed administering medications safely and correctly. The medications and associated documentation are stored safely. Medication reconciliation is conducted when the new medication packs are delivered. The controlled drug management system complies with

		legislation. The medication fridge is checked daily, with recording within recommended ranges. No resident currently self-administers their medication. There are policies and procedure to guide this practice if this is required.
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 six-week rotational menu that has summer and winter variations. This menu has been reviewed by a dietitian as appropriate to people living in long term care. Residents with specific nutritional needs have these met. The kitchen staff get a copy of the nutritional requirements for each resident. Residents are routinely weighed monthly. Nutritional supplements are available to residents assessed as requiring these. Clinical staff report there have been no issues with unintentional weight loss. The kitchen services are based on the Hazard Analysis Critical Control Points (HACCP) principles for food safety. There are appropriate processes in place for the purchasing, preparation, storage and disposal of food that complies with current legislation and guidelines.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	PA Moderate	The previous audit identified improvements in the assessment and care planning documents. These have been partially addressed and progress has been made. Improvements that have been implemented include development of the initial care plan, ensuring the initial care plan covers all aspects of resident's needs, completion of risk assessments, recording family contact and the consistent implementation of six monthly reviews. In the resident files sampled improvements are still required in documenting comprehensive long term care plans that reflect all assessed needs and ensuring the long term care plan covers all the resident needs. As a number of the previous areas have been addressed, the risk rating has remained moderate.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The care and nursing staff were able to describe the interventions required for the residents, though these were not always clearly documented in the resident's files (refer to 1.3.4.2). The care plan format includes the recording of long term and short term needs, goals, required actions (interventions) and the evaluation. The interventions that were recorded in the care plans record how to address these needs. When there is a significant change in the resident condition the care plans are updated to address these needs. If there are short term changes, these are recorded on the short term care plan. Monthly observations are completed and are up to date. All clinical supplies are adequate as confirmed by staff interviewed. It was observed during the audit that residents are accorded respect, privacy and dignity and this was also confirmed during interviews with the residents and families.

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	Activities are appropriate to the needs, age and culture of the residents. The activities coordinator develops a monthly activity planner based on the resident's interests. Resident's files have a documented activity plan that reflect the resident's preferred activities of choice. The younger person has an activity plan specific for their needs, interest, culture and communication needs. Residents were observed involved with a variety of activities. Residents and families interviewed expressed satisfaction with activities programme. Individualised activity plans have been reviewed for effectiveness at least six monthly (or when there is any significant change in participation). The activities coordinator reported that they have group activities and also engage in one on one activity with some residents. Activities are modified according to abilities and cognitive function.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents long term care plans and activity plans are evaluated at least six monthly and updated when there is any significant change. Reviews are documented and included current resident's status, any changes and achievements towards goals. The interRAI assessments are conducted six monthly and the outcomes are used as part of the evaluation process. Six monthly multi-disciplinary reviews (which include family input) are conducted to evaluate the effectiveness of the residents' progress. Family/whanau and staff input is sought in all aspects of care. Short term care plans are developed and reviewed as needed.
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 service has a documented infection control programme which is overseen by the infection control co-ordinator. Monthly data is shared at staff meetings and reported at management level. An annual review of the infection control programme was completed in March 2016. This addresses the previous area of improvement.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that	FA	The infection prevention and control surveillance data documented by staff is collated and monitored by the infection control co-ordinator. This data is reported at RN and staff level as confirmed in meeting minutes sighted. The infection control coordinator can seek expert advice as needed from the DHB. Most infections are treated from laboratory result testing by the general practitioner. For example, there was in increase in gastro-intestinal disturbances in July and August 2016. Laboratory results came back negative. This is well

have been specified in the infection control programme.		documented in a summary of actions taken. The surveillance data collected is appropriate to the size of this aged care setting as demonstrated in the infection control programme. A monthly infection control report and analysis of data was sighted. Management stated that corrective actions are put in place as required. Directors are notified if any concerns arise.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The previous audit identified an area for improvement in relation to enabler use and ensuring the restraint register includes enablers in use. This has how been addressed. There is one resident with enabler use (bed rail) and no recorded restraint use. The file reviewed confirms the enabler is voluntary and the least restrictive option. The residents care plan records the interventions required for the bed rail. This enabler is recorded in the sighted restraint register. The caregivers interviewed demonstrated knowledge of the enabler and the monitoring that they are required to do when the bed rail is up.

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 1.2.3.4 There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.	PA Low	The service has a documented control system to manage the policies and procedures. All polices are approved by management and are available to service providers. There is a system to manage obsolete documents. However, the service has not reviewed all policies and procedures within required timeframes. This was confirmed by the operations manager at the time of audit who stated they are working on towards completion of updates.	Not all policies and procedures have been reviewed within the organisations required timeframes.	Provide evidence that all policies and procedures have been updated to meet identified timeframes and to reflect current good practice and legislative requirements. 180 days
Criterion 1.2.3.8 A corrective action	PA Low	Corrective action plans were sighted for all areas of concern or if a deficit was found. These covered all key components of service delivery including internal audit results and complaints	Corrective actions are consistently developed but they are not always	Provide evidence that all corrective actions are

plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.		management. However not all corrective actions are consistently evaluated. This was an area identified for improvement in the previous audit and remains open with a decreased risk rating.	evaluated to show the outcome and if a service improvement was achieved.	evaluated to show outcome results. 180 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	There is a system in place to show how education for staff is planned on an annual basis. Education covers all aspects of service delivery. The education undertaken by staff is recorded on attendance sheets only, however individual staff training records are not maintained, including the time of attendance (for ensuring adequate training hours are maintained). Staff performance appraisals are required to be conducted annually. Staff appraisals were not sighted in staff files sampled.	Individual staff education records have not been maintained. The length of time for educational sessions is not consistently recorded. Annual staff appraisals are not up to date for any of the staff files sampled.	Maintain individual staff education records, including the length of time for each education session. Conduct annual performance appraisals as required. 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	PA Moderate	The organisation currently uses a national long term medication chart. The medication charts record the required information and are signed by the GP. The medication charts evidenced three monthly reviews. Six of the medication charts evidence transcribing of medications (these charts date back to 2013). Residents with more recent admission do not evidence transcribing, with the GP writing and signing all these long term and short term medication orders. The manager reports that the service is transitioning to a cloud based electronic management system in February 2017. The manager reports that as they are transitioning to the electronic system, the service has not updated the previous medication charts that evidenced the transcribing.	Six of the 10 medications charts had evidence of transcribing.	Provide evidence that medications are not transcribed. 90 days

to comply with legislation, protocols, and guidelines.				
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	Current medication competencies were sighted for two RNs. No other medication competency assessments where evidenced for the rest of the staff who assist with medication management. The manager reports that they have assessed the staff as competent, though this has not been documented. The medication round observed evidenced that that the staff member followed safe and appropriate medication administration.	A current medication competency was not sighted for all staff that assist in medication management.	Provide evidence that all staff who assist in medication management are assessed as competent to perform their role. 90 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 organisation uses a mix of electronic (interRAI) and paper-based assessment tools. In three of the five resident files reviewed, not all the assessed needs have been identified on the long term care plan. Both the rest home and hospital tracer files, and one other supplementary file sampled, did not have all the identified needs recorded. In two of the files sampled, the residents had behaviour of concern, though this was not included in the long term care plan. Four of the five resident files sampled did not include all the required content, as per contract requirements, which address all the residents personal care needs, health care needs, rehabilitation/habitation needs, maintenance of function needs and care of the dying, psychosocial, spiritual and cultural abilities, deficits and needs.	Three of the five resident files sampled did not have long term care plans that recorded all the residents identified needs, goals and interventions. Four of the five care plans sampled did not cover all aspects of the resident's assessed physical, psychosocial, spiritual and cultural abilities, deficits, and needs;	Provide evidence that the long term care plans identify all the residents' needs that have been identified through the assessment process. Ensure care plans cover all required aspects, as per contract requirements. 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.