# Henrikwest Management Limited - Turama House & Catherine Lodge

## 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 The DAA Group 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:** Henrikwest Management Limited

**Premises audited:** Turama House Rest Home||Catherine Lodge Retirement Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 1 March 2017 End date: 2 March 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:** 46

# 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

Catherine Lodge and Turama House are aged care services owned by Henrikwest Management Limited, which is a family owned and operated service. Both facilities provide rest home level care for up to 71 residents, with 46 residents at the service at the time of audit. Residents and family/whanau reported satisfaction with the care and services provided.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included the review of documentation, observations and interviews. The onsite documentation review included a selected number of residents’ files. Interviews were conducted with the management team, clinical and non-clinical staff, residents, family/whanau and a general practitioner to verify the documented evidence.

The service has gained one rating of continuous improvement for the activities related to the communication/reporting project that has been developed and implemented across the facilities. There are no areas requiring improvement identified.

## 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. |

The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are delivered that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a Maori health plan and related policies. There was no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and family is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The services have strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard. The service has an easy to use complaints management system. There is a complaint register that contains any complaint received and actions taken to address any shortfalls.

## 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. |  | Standards applicable to this service fully attained. |

The management team ensures that business and strategic planning is in place to cover all aspects of service delivery at both Catherine Lodge and Turama House. The annual business plan, which is personalised to the services offered and strategic goals, reflects organisational planning outcomes.

The manager is responsible for the overall management of the service at both Catherine Lodge and Turama House. The manager is suitably experienced to run the service. The manager is supported by the management team, senior caregivers/coordinators and registered nursing staff for clinical responsibilities. The management team have a mix of clinical and non-clinical personnel and family members.

Policies are reviewed by the management team annually, or sooner if there are changes in legislation or best practice. The quality and risk performance is reported through weekly reporting, meetings, and monthly analysis of data at both facilities. Quality and risk management activities and results are shared among management, staff, residents and family/whānau, as appropriate.

Corrective action planning is implemented to manage any areas of concern or deficits. The quality systems are linked to gaining improved outcomes for residents. The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established. There are adequate staff numbers each shift to meet the residents’ needs. There is an education programme for all staff available and planned for the upcoming year. Residents` information is accurately recorded, securely stored and is not accessible to unauthorised people. Up-to-date, legible and relevant records are maintained using an integrated hard copy record.

## 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. |  | Standards applicable to this service fully attained. |

The organisation works closely with the local Needs Assessment and Service Coordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. Staff are supported by allied health staff contracted to the provider and a designated GP at one facility and a GP group at the other facility. On call arrangements for support from senior staff are in place. Shift handovers guide continuity of care.

The long-term care plans are individualised, based on a range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents` records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Resident and family interviewed reported being well informed and involved in the care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health and disability services as required, with appropriate verbal and written handovers.

The planned activity programme, provides residents with a variety of individual and group activities and maintains the links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses and senior care staff, all of whom have been assessed annually as competent to do so.

The food service meets the nutritional needs of the residents with special needs being catered for. Policies and procedures guide food delivery services, supported by staff with relevant food safety qualifications. The kitchens on both sites were organised, clean and met food safety standards.

## 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. |

There are processes in place to protect residents, visitors, and staff from exposure to waste and infectious or hazardous substances.

All building and plant complies with legislation with a current building warrant of fitness displayed. Ongoing maintenance ensures the building is maintained to meet the needs of the residents. Fixtures, fittings, floor and wall surfaces are made of suitable materials for the rest home environment.

There are adequate numbers of toilets and showers. There is a mix of single and shared rooms, with each room having enough space and amenities to facilitate independence. Both facilities have an appropriate call system installed. There are external gardens, grounds, decks and court yards for residents and their visitors. The physical environment minimises the risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents.

Routine safety checks and internal audits are performed by maintenance personnel and management. Emergency preparedness was evident with adequate resources being available in the event of an emergency. Staff are trained appropriately in all aspects of health and safety in the work place.

## 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. |

At the time of audit there are no restraints or enablers in use. Policy states that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. Restraint approval and assessment processes are known to staff.

## 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 programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is accessed from the district health board, microbiologist and the general practitioners, as needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education. Aged care specific infection surveillance is undertaken, data is analysed and trended and results are reported to staff. Follow-up action is taken as and when 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 | 45 | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 1 | 92 | 0 | 0 | 0 | 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Catherine Lodge Retirement Home and Turama House use the same policies, procedures and processes to meet their obligations in relation to the Code of Health and Disability Services Consumers` Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed showed that informed consent has been gained appropriately using the organisation`s standard consent form including photographs, van outings, information sharing and releasing information and any treatments that may be required.Establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents unable to consent is clearly defined and documented where relevant in the resident`s records reviewed. Registered nurses and the manager demonstrated understanding of consent and EPOA processes. The care staff were observed to gain consent for day to day care on an ongoing basis.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents/family are provided with a copy of the Code during the admission process, which includes information on the Advocacy Service. Brochures are displayed in both facilities at reception. Family and residents were aware of the Advocacy Service and how to access this and their right to have a support person and/or representative.The registered nurse interviewed was aware of how to access the Advocacy Service. Staff received annual training as part of the Code of Rights ongoing education. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | Residents are encouraged to maintain links with their family and the community by attending a variety of outings and tours, visits, shopping trips and other activities being provided on a regular basis. Family are able and welcome to visit anytime or after hours with consent of the manager. The facilities have unrestricted visiting hours. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Representatives of different churches visit regularly and offer communion to residents that wish this to occur and this was observed on the days of the audit. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The sighted complaints policy and process complies with Right 10 of the Code. The complaint register identified complaints have been managed within policy time frames. The register records all complaints, dates and actions taken. The complaint register also recorded what Right the complaint relates to. There is also a minor complaint register/record, which records the issue and how this is then addressed. There is an annual review of both the serious complaints and minor complaints, with issues and trends reviewed by the management team.Catherine Lodge has had two external complaints since the last audit. One of these has been closed off with no further action required. The other is still under review by the Health and Disability Commissioner. The management team and staff have implemented changes in the reporting and monitoring systems since the complaint was received. Residents and family/whānau confirmed that the management’s open door policy makes it easy to discuss concerns at any time and all spoke highly of the quality of care and service delivery.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service through the admission information provided and discussion with staff. Pamphlets are readily available at both facilities. The Code is displayed at reception at Catherine Lodge Retirement Home and outside the office at Turama House. Pamphlets are available together with information on advocacy services and how to make a complaint. Complaint forms are accessible. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents and family confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, ensuring resident information is held securely and privately, and exchanging verbal information). All residents have their own room. There is one double room at Catherine Lodge Retirement Home but this is not in use presently. A curtain division is installed between the two bed spaces for privacy when required. The manager of the two facilities is the privacy officer. A privacy audit has been completed to ensure the twelve principles of the Privacy Code are adhered to both in policy and in practice.Residents are encouraged to maintain their independence by attending activities in the community and attending visits to clinics or activities of their choosing. Each care plan included documentation related to the resident`s abilities, and strategies to maximise independence.Records reviewed confirmed that each resident`s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.Staff at both services interviewed understood the service policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff and is then provided on an annual basis, as confirmed in staff and training records. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 | Staff support the two residents (one in each service) who identify as Maori, to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau to Maori residents. There is a current Maori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers with the DHB. One of the management team identifies as Maori. Guidance on tikanga best practice is available and is supported by staff who identify as Maori in the facilities. The residents interviewed reported that staff acknowledge and respect their individual cultural needs and there are no barriers observed for Maori residents to access either of the two aged residential care services. There is an assessment plan for Maori residents` to ensure all needs can be effectively met. Staff received relevant education in January 2017.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident`s personal preferences, required interventions and special needs were included in all care plans reviewed (eg, there are many residents from a diverse range of nationalities at both facilities audited, such as, Pacific Islanders, Samoan, Fijian and Indian). One family interviewed spoke highly of all staff and management. Special ethnic days were held through the year to celebrate different cultures and diversity of the residential care population. Interpreter services are accessible from the DHB if required. A resident survey includes evaluation of how well residents` cultural needs are met and this supported that individual needs are being met. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a code of conduct in both the staff orientation and the individual employment contract house rules. Staff are guided by policies and procedures and, when interviewed, demonstrated an understanding of what constitutes inappropriate behaviour and the processes they would follow should they suspect this was occurring. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The services encourage and promote good practice through regular staff meetings and effective communication (eg, the report system which is newly implemented for registered nurses and the manager, the general practitioner (GP) management system/diary utilised where the registered nurses document all requirements such as medication reviews, medication changes, residents needing to be visited and family meetings with the GP). In addition, the service supports up-to-date evidence based policies, input from external specialist services and allied health professionals when required. The general practitioner confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.Staff reported they receive management support for external education and access their own elective education to support their nursing practice. Another example of good practice observed during the audit includes the roster being maintained with more than adequate staff even if the resident numbers are reduced, as is presently the case at one of the two facilities.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family stated they were kept well informed about the changes to their/their relative`s status and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical care reviews. This was supported in resident`s records reviewed. There was also evidence of resident/family input into the care planning process. Staff and the GP interviewed understood the principles of open disclosure, which was supported by policies and procedures that meet the requirements of the Code.Interpreter services can be accessed via the DHB when required. Staff are also available to provide interpretation as and when needed. Family members, and other forms of communication for residents for whom English is not their first language, are used as appropriate.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Catherine Lodge is a 35 bed rest home facility, with 24 residents at the time of audit (including one resident under the age of 65). Turama House is a 36-bed rest home, with 22 residents at the time of audit. Turama House has three residents under the aged of 65 (one on a long term chronic condition contract, the other two with contracts for younger people living with a lifelong disability). Turama House also has two independent living units, in which there are two boarders - these residents do not receive any care services. The service has several residents at rest home level of care who are supported by mental health services. The services are managed to recognise and meet the needs of a range of ages, gender mix and cognitive needs of the residents. The organisation has a business plan which identifies the organisation’s mission statement, vision and philosophy and shows the organisation’s planning process to meet residents’ needs. Strategic planning is undertaken yearly to ensure the services offered meet residents’ needs. This is reflected in the business plan goals and objectives sighted which cover all aspects of service delivery. The business planning includes an assessment of the strengths and weakness of the service. There are formal management meetings two monthly to review progress with the set goals, with more informal verbal and email communications with the owner/general manager. Catherine Lodge and Turama House are managed by a four-person management team. Which include the managing director, general manager (business manager for the three services operated by Henrikwest), the manager (EN) and a rest home coordinator (senior caregiver). The manager (EN) has the main oversight for the provision of care and supports at both Catherine Lodge and Turama House. The manager has over 19 years’ management experience, maintains their enrolled nursing practising certificate and has managed the facilities for the past seven years. The manager and rest of the management team have each had over eight hours of ongoing professional development related to the management of aged care services. The facility is a member of several aged care associations, and receives regular updates on issues related to the management of aged care services. There are registered nurses who support the management team in the clinical service provision. The staff and residents report the members of the management team are supportive, approachable and address any concerns they may have. |
| 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 | During a temporary absence of the manager other members of the management team take on the manager’s role. In addition to the management team, the staff have support from the clinical team and the provider’s other facility on the North Shore, Auckland. The managing director reports confidence in the management team and staff members’ ability to take on the management role during temporary absences of the manager to provide continuity of care. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality improvement plan describes objectives, goals and actions taken. The quality and risk management system is understood and implemented by the staff. This includes the development and updating of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. All corrective actions are reviewed and evaluated. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Information collected informs ongoing planning processes to ensure residents’ needs are met. The policies and procedures are reviewed at least yearly or sooner if there are changes to best practice or legislation. The policies reflected best practice and link to specialist resources and information, such as current pressure injury prevention and management. Staff only have access to the current policies, with staff updated on any changes in policy through staff meetings and the staff notice board. There is an archive system in place for obsolete documents. The key components of service delivery are standing agenda items for management and staff meetings. All data is collected monthly, collated, trended, reviewed by management and corrective actions put in place if any deficits are noted. There is daily RN reporting to management and weekly management review of data (refer to 1.2.3.6). Each key component has a set quality goal which is regularly reviewed and evaluation is documented to indicate how improvements have impacted on resident satisfaction and safety. There is monthly and annual collation, analysis and evaluation of the quality data. The information is shared with staff, residents and family/whānau as appropriate. Information is used to inform business and strategic planning processes. Staff, resident and family/whānau interviews confirmed any concerns raised have been addressed by management and verbal examples of quality improvements were given.Clearly documented information is available to all staff and the continued improvement process is overseen by management. Staff, residents and family/whānau interviewed confirmed they feel included and well informed about any new processes put in place. Some recent quality initiatives include the review of the medication charting system, focus on skin care and recording of the application of topical treatments, advance care planning and the use of the Glasgow Coma Scale after a resident has had a fall. Corrective action processes inform the quality goals to ensure residents’ needs are being met. Corrective action plans have been developed from all quality processes where a deficit has been identified and/or to related to ensuring best practice standards are maintained following staff education or to meet legislative requirement changes. The corrective actions are decided by the management team and shared with staff at handover and at staff meetings. As staff implement the actions, their input into the evaluation of corrective measures taken is documented and discussed. If a corrective action appears not to be working, then actions are changed so the service can reach their required quality goals. This process is clearly documented on the corrective action form, staff meetings and quarterly reports/analysis. Actual and potential risks are identified and documented in the hazard register. Newly found hazards 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 management team understands their obligations for reporting serious harm and essential notifications, including their responsibility to report stage 3 and above pressure injuries. Essential notification forms were reviewed. Staff demonstrated knowledge of when they are required to complete an incident/accident form. There is weekly and monthly analysis of the incident/accident/adverse events. The analysis of the adverse events is used to implement improvements. The ongoing strategies are discussed at staff meetings. The analysis includes the number of falls and the times that falls are occurring for residents who have had increased falls and incidents of challenging behaviours, with strategies implemented to reduce the number of falls or better support the residents to reduce challenging behaviours.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Professional qualifications and annual practising certificates (APCs) are validated on employment and annually. The service maintains a folder of current APCs, sighted for all staff and contractors who require them. The staff files evidenced that good employment processes are implemented, such as recruitment, interview, reference checking and police vetting. After the orientation period, there is then a performance review annually. Orientation includes the essential and emergency systems, handling concerns and complaints, cultural best practice, infection control, incident/accident reporting, managing challenging behaviours and restraint minimisation. Staff reported that the orientation and induction gave them an understanding of their role and responsibilities. The staff have access to in-service and external education. The education programme covers the essential components of service delivery for rest home level of care and the service’s focus on management of residents with mental health issues and other specific health issues for current residents. The service also accesses ongoing education support from the DHB aged residential care programme, gerontology nurse specialists, other local aged care facilities and palliative care services. The education includes pressure injury minimisation and management. Attendance records are kept for the education that staff have attended, as was sighted in each of the staff member’s personnel files and attendance sheets.A RN who is part of the Henrikwest services currently completes the interRAI assessments and has completed their interRAI competency training. Two RNs who work across Catherine Lodge and Turama House are currently doing their interRAI training. Three members of the management team have completed the managers’ level of the interRAI training.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is clearly documented policy on staffing levels and skill mix to meet the needs of residents requiring rest home level of care. There is at least one RN on duty Monday to Friday in across both facilities and on call after hours. In addition to the direct care staff, there is a coordinator (senior caregiver) in each facility and management team that are on duty Monday to Friday are based at Catherine Lodge three days a week and Turama House two days a week, though are flexible with these days based on the needs of the residents and staff. The RNs share after hours on call and the GP practice is available after hours. There is at least one staff member on duty each shift who has current first aid qualifications. There are appropriate staffing levels for activities, cooking and cleaning. Staff reported they have sufficient time to complete the duties they are required to do each shift. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident`s name, date of birth and National Health Index number (NHI) are documented on all pages of residents` information sighted. All demographic, personal, clinical and health information was fully completed in the sample of residents` records reviewed. Clinical notes were current and integrated. Records reviewed were legible and entries have the date, name and designation of the person making the entry identifiable.Archived records are held securely on site and are readily retrievable. Residents` records are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| 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 | Residents enter the service when their required level of care has been assessed and confirmed by the Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or family are encouraged to visit the facility prior to admission and meet with the manager. An information brochure is available for each facility. The organisation seeks updates and information from NASC for those residents accessing respite care.Family members interviewed stated they were satisfied with the admission process and the information that had made available to them on admission. Records reviewed contained demographic details, NASC interRAI assessments and signed admission agreements completed in accordance with contractual requirements. The initial nursing assessment and care plans were in all residents’ records reviewed. A full interRAI assessment was completed by the registered nurses within the 21-day timeframe after admission.  |
| 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 co-ordinated manner, with an escort as appropriate. The services use the DHB`s `yellow envelope` system to facilitate transfer of residents to and from the acute care services. There is open communication between services, the resident and the family. At the time of transfer between services, appropriate information, including a copy of the resident information, the last interRAI assessment, and medical records is provided for the ongoing management of the resident. All referrals are documented in the progress records. An example reviewed of a resident recently transferred to the DHB showed the family were kept informed during the transfer process.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.A safe system for medicine management was observed at each facility on the days of the audit. The staff involved demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.Medications are supplied to the facilities in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. The contracted pharmacist is involved and an audit was performed 30 September 2016.There were no controlled drugs or standing orders are not used at either facility, but guidelines are available.The records of temperatures for the medicine fridges are within the recommended range. Locked medication trollies are used by the staff.Good prescribing practices noted include the prescriber`s signature and the date recorded on the commencement and discontinuation of medicines. All requirements were met. The required three monthly GP review was consistently recorded on the medicine records reviewed.There were no residents self-administering medications at the time of the audit. Appropriate processes are in place to ensure this is managed in a safe manner.Medication errors are reported to the manager and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for analysis of any medication errors, and compliance with this process was verified. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The contracted dietitian has reviewed the menu plans (3 February 2017) as being suitable for older persons living in long term care. Recommendations/suggestions by the dietitian are being followed-up. The menu plans are seasonal summer/winter. The menu plans are developed on a four-weekly cycle, rotational and varied. On admission to this service the registered nurses complete an initial nutritional assessment inclusive of dietary requirements and any special needs are identified are documented. A copy of this assessment is provided to the cook at each facility. The cook interviewed takes into consideration any preferences, likes and dislikes to meet the needs of each individual resident. Special diets are catered for such as gluten free, high protein and diabetic diets.Home baking is provided by the two cooks, one at each facility, for morning and afternoon teas. Additional beverage rounds included smoothies and some residents are provided with additional supplement high caloric beverages as required. Any prescribed supplements were recorded on the medication record. The residents and family interviewed reported satisfaction with the meals and fluids provided.The cooks are responsible for all aspects of food procurement, production, preparation, storage and checking deliveries and disposal of any food. Food orders are listed according to the menu plans by the cook and given to management who are responsible for ordering all food stuffs. Current legislation and guidelines are available and are complied with. Fridge and freezer temperature recordings are undertaken and documented and meet requirements.The manager is advertising for a weekend cook for one of the facilities presently. The cooks have each completed relevant food hygiene and food safety training and this was verified in the staff personal records sighted. The cook interviewed has also completed first aid training and a first aid box was available in each kitchen.Care staff were observed assisting residents` in the dining room at both facilities. |
| 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 | If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the service offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family/whanau. There is a clause in the access agreement related to when a resident`s placement can be terminated. The manager is well informed of the processes to follow in the event of this occurring. The resident register is updated at the time of discharge/transfer. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Information is documented using validated nursing assessments such as interRAI and additional recognised tools as required such as pain scale, falls risk, skin integrity and pressure injury risk, nutritional profile and/or depression scales, to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of residents related information. All residents have current interRAI assessments completed by the trained registered nurses. Four management staff have completed the management interRAI requirements. A schedule was reviewed of the completion of all interRAI assessments for both services and the review dates are flagged accordingly with the next planned review date. Assessments are completed earlier if required or in the event of a resident being transferred to another Health and Disability Service in the community. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The long-term care plans evidence service integration with progress records, activities records, medical and allied health professional`s notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Behavioural charts are developed and implemented as required and monitored for effectiveness. Any changes in management or de-escalation techniques are updated to guide staff and to ensure the plans are current. Relapse plans are documented for those residents` under the mental health services with strategies in place. The mental health crisis team is available if and when required. Residents and staff reported participation in the development and ongoing evaluation of care plans. Continuity of care delivery is promoted at both sites by staff and management. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident`s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is maintained. Care staff confirmed that care was provided as outlined in documentation. Interventions are consistent and contribute to, meeting the residents` needs and goals set. The mental health goals and interventions are documented to best guide the care for these residents, with regular contact with the community nurse and key workers involved. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents` needs. |
| Standard 1.3.7: Planned ActivitiesWhere 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 activities programme is provided by three activities staff. The activities officers belong to a support group in the region. One of the activities officers works across the organisation’s three sites. The programmes for each site are developed and implemented. Activities reflect resident`s goals, ordinary patterns of life and include community activities. There are many shared events organised, as well as individual and group activities. The activities officer interviewed explained the programme. External entertainers are encouraged; birthdays are celebrated and large functions with family involved are held several times a year and photographs were available. Attendance at activities is recorded and records were sighted. The activities officer interviewed is fully aware that attendance is voluntary and is respectful of individual resident’s choices.All residents are assessed and a social and family history is obtained to ascertain resident`s needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate a programme that is meaningful to the residents. The individual activities need of residents are evaluated six monthly and as part of the formal six monthly care plan review. A schedule is available six monthly to use for the reviews. Additional activities are available for those with mental health issues and or the younger persons disabled and include outings of their choice and activities they enjoy. Resident safety is promoted with all activities organised.The planned monthly activities match the skills, likes and interests identified in the assessment data reviewed. Residents interviewed at both facilities enjoyed the activities and participated as much as possible. Residents are involved in the programmes and residents’ meetings are held. Minutes of the meetings were maintained. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care was evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the registered nurse.Formal care plan evaluations, occur every six months in conjunction with the six monthly interRAI reassessment or as residents` needs change. Evaluations were documented by the RN. Where progress was different from expected, the service responds by initiating changes to the plan of care. Short term care plans were used for short term issues for any individual resident. These plans were reviewed consistently and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Wound care plans were evaluated each time the dressing was changed. Residents/family interviewed provided examples of involvement in evaluation of progress and any resulting 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 another health and disability service providers. Although the services have a resident doctor, residents may choose to use another medical practitioner. If the need arises for non-urgent services, the GP sends a referral to seek specialist input. Copies of referrals were sighted in resident`s records reviewed. Referrals are followed up by the manager or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as transferring a resident to the DHB in an ambulance if required. |
| 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 | The laundry and chemical storage areas at both facilities are secure and provided appropriate storage of waste, infections or other hazards materials. The general waste disposal and recycling is conducted by the local council. Both facilities maintain hazardous substances register, with copies of safety data sheets sighted. Any clinical waste and sharps disposal is conducted by contracted service providers. Personal protective equipment (PPE), such as disposable gowns, gloves and eye protection is available. The staff were observed to be using the appropriate PPE and demonstrated knowledge of when to use the PPE. The staff receive annual training on the management of waste and use of PPE. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Current building warrants of fitness were displayed at both facilities. A monthly safety inspection was recorded, this included environmental inspections, inspection of the furnishings and equipment and review of the civil defence supplies. The electrical equipment evidenced current test and tag inspection labels, appropriate to the type of equipment and environment. Annual calibration of the medical equipment has been conducted. There is a monthly recording of the hot water temperatures, and the readings were within the required range. The physical environment at both facilities minimises the risk of harm with uncluttered corridors with secured hand rails. The floor surfaces are intact. Some carpeting is showing signs of generalised wear and tear, with the service in the process of replacing the carpet. There is ramp and stair access to external areas. There are courtyard and deck areas for the residents, which provides covered seating. There is some generalised wear and tear at both facilities that is reflective of the age of the buildings, though nothing that poses a safety or infection control risk. There is ongoing maintenance and refurbishment plans for both facilities. There was a bathroom and toilet at Turama House under renovation (to replace peeling and cracked floor surfaces). The residents and family/whanau reported satisfaction with the environment at both Catherine Lodge and Turama House.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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 | Catherine Lodge has a mix of ensuite and communal shower and toileting facilities. The facilities are in each of the wings that provide adequate numbers for convenience of access to the residents. There are designated staff and visitor facilities. The surfaces are intact in the toilet/shower facilities. The residents report satisfaction with the toilet and showering facilities. Turama House has a bathroom and shower under renovation at the time of audit. There are still sufficient numbers of toileting and showering facilities available during the renovation. The service has a mix of accessible showers/toilets, single ensuite toilets and shared ensuite toilets in both the upper and lower levels of the service.  |
| 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 | Catherine Lodge has one shared room that has a dividing retractable door, with all other rooms being single occupancy. There is enough space in the rooms to accommodate the resident and any mobility equipment they have. Turama House can two shared rooms (current one was being used as an office space and the other was not occupied at the time of audit). All rooms currently have single occupants and the rooms have sufficient space for the resident and service delivery. All occupied rooms across both locations have the resident’s personal belongings. The residents and staff report adequate space in each of the rooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Catherine Lodge has one main lounge and dining area. Each wing has a smaller lounge area. Turama Lodge has lounge and dining facilities on both levels. There is adequate space in both facilities so lounge, dining and activities do not impact on each other. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The environmental audit and laundry services audits record the effectiveness of the laundry and cleaning processes, including waste management procedures. Both these internal audits record full compliance. The chemicals are securely stored in a locked cupboard and the laundry at both Catherine Lodge and Turama House. The staff demonstrated knowledge of the cleaning and laundry process, which reflects current infection control procedures. The residents and family/whanau reported satisfaction with the cleaning and laundry services. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Each of the facilities has civil defence supplies for emergency use, this included storage of drinking water and food. There is emergency lighting and back up gas supply for cooking and heating of water. The emergency equipment is inspected monthly by both internal auditing and by the contracted fire/emergency inspection company’s independent qualified person. The six-monthly evacuation drills were recorded for both facilities.There is an approved evacuation scheme with a compliance schedule for Catherine Lodge and Turama House. There is signed approval of the amendments. Staff records identified emergency training and the staff demonstrated knowledge of the actions to take in an emergency. At Catherine Lodge and Turama House each room, bed space and toilet/shower facilities have access to a call bell. When activated there is an audible alert and a light on a control panel to identify which room has activated the call bell. Night time security processes are conducted by the staff, which includes the locking of external doors and windows. The evening staff do rounds to ensure the doors and windows are locked. If staff, residents or visitors require access in the evening, there is a door bell. Catherine Lodge and Turama House have a security camera system that monitors the car park, external grounds and common areas within the facilities. There are notices and verbal inform provide to staff, residents and visitors of the security cameras. The external doors at Catherine Lodge are alarmed at night, which alert staff to when doors are opened.  |
| 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 | All areas used by the residents have adequate natural light, heating and ventilation. Each resident’s room has at least one external opening window. There is heating throughout both buildings. The residents and family/whanau reported satisfaction with the lighting, heating and ventilation of the building. All residents reported that the facilities were comfortable throughout the year and with changing seasons. |
| Standard 3.1: Infection control managementThere 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 services provide managed environments that minimise the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a current infection control manual which is accessible for staff. The infection control programme is reviewed annually, which is next scheduled for this month (March 2017). The manager is the designated infection prevention and control coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly and tabled at the quality meetings. This was verified by sighting the meeting minutes. The committee includes the manager and a senior caregiver.The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities. |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection prevention and control coordinator has appropriate skills, knowledge and qualifications and has attended relevant study days as verified in the training records. The infection control team at the DHB, the GPs and the community laboratory are available if additional support/information is required.The manager has access to residents` records and diagnostic results to ensure timely treatment and resolution of any infections. There have been no outbreaks of infection since the last audit. Resources are available to support the programme should there be an infection outbreak.  |
| Standard 3.3: Policies and proceduresDocumented 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 infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in 2016 and include appropriate referencing. Care delivery, cleaning, laundry (caregivers) and kitchen staff were observed following the organisation’s policies, such as appropriate use of hand-sanitisers, good hand-washing techniques and use of personal protective resources appropriate to the setting. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Priorities for staff education are outlined in the infection control programme plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation/induction and that this was provided on an ongoing basis. Education is provided by the manager and/or the registered nurses at the staff meetings. Content of the training was documented and has been evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. Education with residents is generally on a one-to-one basis and has included hand hygiene and increasing fluids during the hot weather. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and any other infections. When an infection is identified, a record is documented on the infection reporting form. The infection control coordinator reviews all reported infections. Monthly surveillance data has been collated and analysed to identify any trends, possible causative factors and required actions. Results of surveillance have been shared with staff at both facilities at regular staff meetings and at shift handovers. Graphs have been produced that identify trends for the current year and comparisons against the previous years, and this is reported at the quality meetings with the management team. Infection rates at both facilities were low.Any new infections and any required management are discussed at handover, to ensure early interventions occurs. Graphs were displayed for staff to more clearly review results. Surveillance for the two facilities was appropriate for the size of the organisation and types of services provided. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is no restraint or enablers in use at both services. The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. The use of enablers is voluntary and the least restrictive option to meet the needs of the resident. Policy contains all necessary documentation related to the use of restraint. Restraint would only be used if a resident posed a risk to themselves or others. There is an annual review of the restraint policies and education related to restraint minimisations and safe use. Staff verbalised their understanding and knowledge related to restraint and enabler use. |

# 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.

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

# 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | The organisation has conducted a continuous improvement project related to the internal reporting processes. The project involved reviewing the quality improvement systems through communication, review, audits, verification activities, validation and control measures, corrective actions and updating the quality systems. The organisation implemented daily and weekly reporting forms. The forms revolved around the monitoring of areas in the rest homes that are contractually required and identified more attention and focus to ensure standards were maintained and improved on. The project and ongoing implementation has increased communication within and between the teams and has enabled better allocation of resources to make improvements to the quality of care and service delivery. The reporting system from managers and RNs has established higher levels of service delivery, fewer errors in documentation and a reduction of incidents.  | The achievement of the quality projects and quality management systems is rated beyond the expected full attainment. The quality improvement project sampled have a documented review process which includes analysis and reporting of findings to management, staff and residents. The project documentation evidences action taken based on findings and improvement to communication, continuity of service delivery and reduction of incidents. Resident safety has been measured through the reduction of incidents, accidents and infections through the identification of early warning signs more efficiently. The residents report high satisfaction with the care and services provided at both Catherine Lodge and Turama House.  |

End of the report.