# T M & D L Beer Holdings Limited - Kenwyn Rest Home & Hospital

## Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** T M & D L Beer Holdings Limited

**Premises audited:** Kenwyn Rest Home & Hospital

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

**Dates of audit:** Start date: 2 March 2017 End date: 3 March 2017

**Proposed changes to current services (if any):** This audit also included verifying the service as suitable to provide medical level care under their current hospital certification.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 52

# 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

Kenwyn Rest Home and Hospital is privately owned and operated. The service provides care for up to 59 residents requiring hospital, rest home and dementia level care. On the day of the audit, there were 52 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, staff and management.

The service is overseen by a clinical operations manager/registered nurse who has been in a leadership role for five years. The clinical operations manager/registered nurse is supported by a general manager. Residents, family and the GP interviewed spoke positively about the service provided.  
This audit has identified the following areas requiring improvement: care planning, interventions, medication, chemical safety and maintenance.

## Consumer rights

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

Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is presented to residents and their families during entry to the service. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Residents and family report communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

## 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. |

Services are planned, coordinated and are appropriate to the needs of the residents. The clinical operations manager/registered nurse and the general manager are responsible for the day-to-day operations of the care facility. The clinical operations manager/registered nurse is supported by a registered nurse (second in charge) and team of care staff. Quality and risk management processes are implemented. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. The health and safety programme meets current legislative requirements. Adverse, unplanned and untoward events are documented and investigated. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type.

## 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 clinical operations manager takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. They are clearly written and caregivers report they are easy to follow. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site and the menu has been reviewed by a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Rooms are individualised. There are large spacious lounges and dining areas. There are adequate toilets and showers. The internal areas are able to be ventilated and heated. There is sufficient space to allow the movement of residents around the facility using mobility aids. The outdoor areas are safe and easily accessible. Cleaning services are well monitored through the internal auditing system. Laundry is completed on-site by dedicated laundry staff.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The restraint coordinator is a registered nurse who is responsible for ensuring restraint management processes are followed. On the day of audit there were five residents utilising restraint (as needed) and one resident using an enabler.

## Infection prevention and control

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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 | 3 | 2 | 0 | 0 |
| **Criteria** | 1 | 95 | 0 | 3 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The Code of Health and Disability Consumers’ Rights (the Code) brochures are provided to residents and their families. Policy relating to the Code is implemented. Two managers (one general manager and one clinical operations manager/registered nurse) and twelve care staff (six caregivers, two registered nurses (RNs), one clinical support and three activities coordinators) interviewed confirmed their understanding of the Code and provided examples of how the Code is applied to residents’ cares. Staff receive training about the Code during their induction to the service. This training continues through the mandatory staff education and training programme. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Eight resident files sampled (four rest home, two hospital and two dementia) demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative’s lives. All resident files sampled had a signed admission agreement signed on or before the day of admission and consents. Residents in the dementia unit had copies of EPOA on file and where these were missing, a process was in place to obtain a copy. Where copies of the EPOA were on resident files, there was evidence that the EPOA had been enacted or was in the process of being enacted. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | HDC advocacy brochures are included in the information provided to new residents and their family during their entry to the service. An advocacy poster is displayed in a visible location. A resident advocate has been appointed to the service with contact details posted in a visible location. Staff receive regular education and training on the role of advocacy services, which begins during their induction to the service. Education is provided by the local HDC advocacy service.  Residents and family interviewed were aware of the role of advocacy services and their right to access support. The complaints process is linked to advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with friends and community groups. Assistance is provided by the care staff to ensure that the residents participate in as much as they can safely and desire to do, evidenced through interviews and observations. Interviews with the rest home level residents confirmed that they are encouraged to remain active in their community and participate in social activities external to the aged care facility. Examples include RSA, van outings and church services. One rest home resident interviewed during the audit was getting ready to depart for the day to attend her local Mahjong group. Local entertainers regularly visit the facility. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and families during entry to the service. Access to complaints forms are located at reception. A register of all complaints received is maintained. Five complaints were received in 2016 and none in 2017 (year to date). Documentation including follow-up letters and resolution demonstrated that complaints are well-managed.  Discussions with residents and families/whānau confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information that is provided to new residents and their families. The clinical operations manager and/or clinical support staff discuss aspects of the Code with residents and their family on admission. Discussions relating to the Code are also held during the monthly resident/family meetings. All ten residents (six rest home, four hospital) and ten family (five hospital and five rest home) interviewed reported that the residents’ rights were being upheld by the service. Note: no families from the dementia unit were available for interview during the audit. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The residents’ personal belongings are used to decorate their rooms. Privacy signage is on communal toilet doors.  The care staff interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They reported that they promote the residents' independence by encouraging them to be as active as possible. All of the residents and families interviewed confirmed that the residents’ privacy is respected.  Guidelines on abuse and neglect are documented in policy. Staff attend mandatory education and training on abuse and neglect, which begins during their induction to the service. Links are in place with Age Concern for referral if abuse and/or neglect is suspected. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The care staff interviewed reported that they value and encourage active participation and input from the family/whānau in the day-to-day care of the residents. Links are established with Tui Pa Marae. Resident rooms are blessed following a death.  Staff education on cultural awareness begins during their induction to the service and continues as a regular in-service. The caregivers interviewed provided examples of how they ensure Māori values and beliefs are upheld by the service. There was one resident living at the facility that identified as Māori during the audit but was unable to be interviewed. Staff reported that they sing in te reo Māori with the resident. Cultural values and beliefs that are identified are documented in the resident’s care plan. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies the residents’ personal needs and desires from the time of admission. This is achieved in collaboration with the resident, family and/or their representative. The staff demonstrated through interviews and observations that they are committed to ensuring each resident remains a person, even in a state of decline. Beliefs and values are discussed and incorporated into the residents’ care plans, evidenced in all eight care plans reviewed (four rest home, two dementia and two hospital). One resident file reviewed from the dementia unit had a short autobiography added to the file. Residents and family interviewed confirmed they were involved in developing the resident’s plan of care, which included the identification of individual values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Professional boundaries are discussed with each new employee during their induction to the service. Professional boundaries are also described in job descriptions. Interviews with the care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Good practice was evident. A registered nurse is on-site 24 hours a day, 7 days a week. A nurse practitioner (NP) visits the facility once a week. One of four local general practitioners (GPs) holds a GP clinic once a week. Residents are reviewed either by the NP or GP every three months at a minimum.  The service receives support from the district health board (DHB) which includes (but is not limited to) specialist visits (gerontology nurse specialist, mental health services and cardiopulmonary specialist). Support is also provided through Hospice New Zealand. Physiotherapy services are available on an as needed basis through a local provider and/or the DHB community physiotherapist.  The clinical operations manager has recently completed her post graduate diploma in health science advanced nursing stream, specialising in common and chronic health conditions (June 2016). Commencing in Feb 2017 she is now authorised to implement standing orders for Health Te Aroha GPs for common/uncomplicated conditions.  A van is on-site for regular outings. Residents and family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A resident/family satisfaction survey is completed annually and confirmed satisfaction with the services received.  The GP was unavailable for interview. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The policy also describes that open disclosure is part of everyday practice. The care staff interviewed understood about open disclosure and providing appropriate information and resource material when required.  Families interviewed confirmed they are kept informed of the resident’s status, including any events adversely affecting the resident. A family communication sheet is held in the front of the residents’ files. The clinical operations manager reports that she contacts family a minimum of monthly to update them on the resident’s health status. Twenty-five accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event.  An interpreter service is available and accessible if required through the citizens’ advice bureau. Families and staff are utilised in the first instance. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kenwyn Rest Home provides care for up to 59 residents at rest home, hospital (geriatric and medical) and dementia level of care. The dementia unit provides care for up to 19 residents. The rest home and hospital has 40 beds (8 dual-purpose, 12 hospital and the remaining rest home level). On the day of the audit, there were 15 residents in the dementia unit, 13 hospital residents and 24 rest home residents. All residents were on the aged residential care contract.  This audit also included verifying the service as suitable to provide medical level care under their current hospital certification.  An annual business plan has been developed that includes a philosophy, values and measurable goals. Business goals documented for 2016 have been reviewed and summarised in preparation for the development of the 2017 business plan.  An experienced clinical operations manager manages the service. She is a registered nurse (RN) with 20 years of nursing experience in aged care and has been in a leadership role at this facility for the past five years. She receives support from a general manager with a business background and a team of care staff that includes six RNs. She is on-site three days a week and the general manager is on-site two days a week. Both managers are also responsible for operations at another aged care facility.  Both managers have completed at least eight hours of training related to management of an aged care facility, relevant to their role and responsibilities. |
| 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 the absence of the clinical operations manager/RN, the second in charge (2IC) RN assumes clinical responsibilities. Administrative responsibilities are delegated to the general manager. The clinical operations manager is responsible for administrative responsibilities in the absence of the general manager. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | A quality and risk management programme is in place. Interviews with the general manager, clinical operations manager/RN, care staff, one cook, one cleaner, one maintenance and one laundry staff reflected their understanding of the quality and risk management systems that have been put into place.  Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies.  Quality data collected is collated and analysed using a run chart methodology. Hospital falls have reduced significantly over the past two years. Quality data is regularly communicated to staff via monthly staff meetings and through the use of graphs that are posted each month in the staff room.  An internal audit programme is being implemented. Areas of non-compliance include the initiation of a corrective action plan with corrective actions signed off to evidence their implementation. There was evidence in the monthly staff meetings to verify staff are informed of audit results and corrective actions. A quality improvement register is maintained that keeps a running tally of quality initiatives. Examples since the last audit included (but were not limited to): upgrading the garden in the dementia unit, improving staff orientation by implementing a more structured mentoring programme and purchasing new equipment (e.g. washing machine).  A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (clinical operations manager) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility’s health and safety programme. The hazard register is regularly reviewed (last review 15 August 2016). |
| 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 | An accidents and incidents reporting policy is in place. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical evaluation of residents following an adverse event is conducted by a registered nurse and was evidenced in all 25 accident/incident forms selected for review.  Adverse events are linked to the quality and risk management programme. Staff are kept informed in a timely manner regarding accidents and incidents and the implementation of strategies to reduce the number of adverse events.  The clinical operations manager is aware of the requirement to notify relevant authorities in relation to essential notifications with an example provided following a police call out. |
| 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 | There are human resources management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity, evidenced in eight staff files randomly selected for review (six caregivers, two registered nurses).  Copies of practising certificates are kept on file. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Evidence of completed induction checklists were sighted in all eight staff files. Annual staff appraisals were up to date.  An in-service education programme is being implemented. Regular in-services are provided by a range of in-house and external speakers including (but not limited to): nurse specialists, Aged Concern and the Health and Disability Advocacy Service.  Thirteen of fifteen caregivers who work regularly in the dementia unit have completed their New Zealand Qualification Authority (NZQA) approved dementia qualification. The remaining two caregivers have been employed less than one year and are enrolled. |
| 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 includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. A clinical operations manager/RN is on-site three days a week.  The rest home/hospital (twenty-four rest home, thirteen hospital residents) is staffed with one RN each shift. A second RN is on-site two days a week (when the clinical operations manager is unavailable) to complete interRAI assessments. The dementia unit (15 residents) is overseen by the RN covering the rest home/hospital.  There are adequate numbers of caregivers in the dementia unit and rest home/hospital. The night shift is staffed with two caregivers in the rest home/hospital (plus the RN) and one caregiver in the dementia unit. Extra staff can be called on for increased resident requirements.  Activities staff are rostered seven days a week in the dementia unit and five days a week in the rest home/hospital. There are separate domestic staff who are responsible for cleaning and laundry services.  Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in secure rooms. Archived records are secure in a separate locked storage facility located on the premises.  Residents’ files demonstrate service integration. Entries are legible, dated, timed and signed by the carer and include their designation. |
| 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 | The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The clinical operations manager screens all potential residents prior to entry and records all admission enquires in a hard copy system. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the general manager and the clinical operations manager. The admission agreement form in use aligns with the requirements of the ARRC contract. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur. |
| 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 Low | Sixteen medication charts were reviewed (eight rest home, four hospital and four dementia). There are policies available for safe medicine management that meet legislative requirements. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed all resident’s medication three-monthly and all allergies were noted.  All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service uses robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.  The standing orders in use comply with the Standing Orders Guidelines 2016. There were two rest home residents self-medicating on the day of audit, however not all the required documentation had been completed.  The medication fridge temperature is recorded regularly and these are within acceptable ranges. |
| 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 | All meals at Kenwyn Rest Home are prepared and cooked on-site. There is a food services manual in place to guide staff. The food service menu was last audited by a dietitian in June 2015. There is a four-weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met.  Meals are plated and served from the kitchen to the rest home and hospital residents in the dining room and to the residents in the dementia unit. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues.  Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed or are currently completing their food safety course.  There are specialised crockery such as lip plates, mugs and utensils to promote resident independence with meals.  Residents have the opportunity to provide feedback on the menu and food services through the resident meeting and resident surveys. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes. |
| 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 | The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed. Assessments were reviewed at least six-monthly or when there was a change to a resident’s health condition in files sampled. The interRAI assessment tool is implemented. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The long-term care plans reviewed described the support required to meet the resident’s goals and needs, however not all residents’ care needs had been noted in a care plan. Care plan interventions did not always document interventions in sufficient detail to meet the residents’ needs. The care plans sampled identified allied health involvement. The interRAI assessment process informs the development of the resident’s care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. The service uses the interRAI care plan template. Staff interviewed reported they found the plans easy to follow. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Registered nurses (RNs) and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g. to the district nurse, hospice nurse, or the mental health nurses). If external medical advice is required, this will be actioned by the GPs or nurse practitioner. Staff have access to sufficient medical supplies (e.g. dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.  Wound assessment, monitoring and wound management plans are in place for residents with wounds which includes one resident with a stage I (facility acquired) pressure area (link hospital tracer 1.3.3). All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service and nurse practitioner.  Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as two-hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. Not all monitoring had been completed as required. |
| 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 | Three activities coordinators are employed to operate the activities programmes for all residents. The programme operates five days a week. There is a separate programme for residents in the dementia unit. Each resident has an individual activities assessment on admission, which is incorporated into the interRAI assessment process. An individual activities plan is developed for each resident by the activities coordinators in consultation with the registered nurses. There is a 24-hour activity plan documented for residents in the dementia unit. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All long-term resident files sampled have a recent activity plan within the care plan and this is reviewed at least six-monthly when the care plan is evaluated or a further interRAI assessment occurs.  Residents and families interviewed commented positively on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP or nurse practitioner. Reassessments have been completed using interRAI LTCF and other relevant assessment tools for residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan (link 1.3.5.2). |
| 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 | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs or nurse practitioner Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident’s condition had changed and the resident was reassessed. |
| 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. | PA Moderate | There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly but not all stored safely throughout the facility. Safety data sheets are available. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building has a current building warrant of fitness which expires on 11 April 2017. There is a maintenance person employed 20 hours per week to address the reactive and planned maintenance programme. Not all reactive maintenance had been completed. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have shared ensuites and other residents share communal toilets and showers. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares. |
| 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 | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are several large lounges and dining areas. The lounges and dining rooms are accessible and accommodate the equipment required for the residents. These areas are large enough to cater for activities. Residents are able to move freely through and around these areas and furniture is placed to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry and cleaning is completed on-site by dedicated staff. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness and the laundry services provided. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures and a civil defence plan are documented for the service. Fire drills occur every six months at a minimum. The orientation programme and mandatory education and training programme include fire and security training. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.  There are adequate supplies available in the event of a civil defence emergency including food, water and blankets. A gas barbeque is available.  A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity.  There is a minimum of one staff available 24 hours a day, 7 days a week with a current first aid/CPR certificate. |
| 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 | General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight. |
| 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 | Kenwyn Rest Home has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The clinical operations manager is the designated infection control coordinator with support from all staff as members of the infection control team. Infection control is discussed at all staff meetings. Minutes are available for staff. Spot infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The clinical operations manager is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are Kenwyn infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinator has completed education in infection control as part of their post graduate studies and has also completed online infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in Kenwyn’s infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at all staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical operations manager. There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around restraints and enablers. Five residents (four hospital residents were using bedsides as a restraint and one dementia resident was using a lap belt) were using restraint. One enabler (bedsides) was in use for a hospital level resident. An assessment was completed and written consent was provided by the resident for the use of this enabler.  Staff interviews confirmed their understanding of the differences between a restraint and an enabler.  Staff receive regular training around restraint minimisation that begins during their induction to the service. A restraint competency questionnaire is completed by staff each year. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is an RN (2IC). Restraint minimisation policies and procedures describe approved restraints. Restraint use is discussed in the monthly staff meetings. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The restraint coordinator is responsible for assessing a resident’s need for restraint. Restraint assessments are based on information in the resident’s care plan, discussions with the resident and family and observations by staff. Assessment tools are in place for restraint use. All residents’ files where restraint was being used were selected for review. Each resident using restraint had a restraint assessment completed. Family had signed informed consent for restraint use. The restraint assessment addressed risks associated with restraint use. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | A restraint register is being implemented. The register identifies the residents that are using a restraint or an enabler. Five residents were listed on the register (four hospital and one dementia). The types of restraints used were bedsides and lap belts.  The five restraint assessments reviewed identified that restraint is being used only as a last resort. The restraint assessment process includes determining the frequency of monitoring while restraint is in use. Restraint use was linked to the residents’ care plans, although interventions to manage the associated risks (e.g. timeframes determined in the assessment) were missing in four of the five files (link 1.3.5.2). Restraint policy indicates that all residents are monitored two-hourly at a minimum. Care staff have been updated on restraint procedures and documentation requirements and take responsibility to ensure restraint monitoring is correctly documented. Monitoring forms for the files reviewed were completed and included when the restraint was put on and when it was taken off. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Restraint evaluations take place six-monthly in conjunction with the care plan reviews. Restraint use is also discussed in the monthly staff meetings. This was confirmed in the staff meeting minutes. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint minimisation programme is discussed and regularly reviewed by the clinical operations manager and restraint coordinator. The reviews include identifying trends in restraint use, reviewing restraint minimisation policies and procedures and reviewing the staff education and competency assessments. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | The service has an assessment, consent, monitoring and review process in place for residents who wish to self-medicate. On the day of audit one resident was self-administering an inhaler and had not completed the required assessment or consents and there was no monitoring or record of the administration of the inhaler. | One of two residents (rest home) self-administering medication (inhaler) had not completed the required assessment or consenting process and no checks were being completed to see that the medication had been taken as prescribed. | Ensure that all residents who are self-medicating have completed the necessary assessment and consent process.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The RN is responsible for documenting a care plan that outlines to all staff the support and interventions required to meet the care needs of the resident. In the files sampled care plans had not been documented for all identified care needs. Not all interventions for assessed care needs were documented in sufficient detail to guide the care staff. The assessment and consenting process for the use of restraint identifies the risks associated with the use of the restraint. Not all restraint care plans documented the interventions required to manage the identified risks. | (i)Three of eight care plans reviewed (one rest home, one hospital and one dementia), did not have care plans documented for the management of indwelling catheters, management of ESBL and a diabetic management plan for a resident on insulin.  (ii) Five of eight files sampled (two hospital, two rest home and one dementia) did not have interventions documented in sufficient detail for the management of urosepsis, right-sided blindness, de-escalation strategies for behaviours, weight loss, Parkinson’s symptoms and the risk of developing a pressure injury.  (iii) Four of five residents using restraint (three hospital, one dementia) did not have interventions documented in the care plan to manage the risks associated with the use of the restraint that were identified in the assessment and consenting process. | (i)-(ii)Ensure that care plans are documented for all identified care needs and documented within sufficient detail.  (iii) Ensure that interventions to manage the risks associated with the use of restraint are documented in the care plan.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The RN reviews information gathered from assessments, monitoring charts, observations and interviews with residents, staff and families to document the interventions required in the care plan. The care plan describes the type and frequency of monitoring the resident requires. Not all required monitoring was completed as noted in the care plan and not all monitoring that was completed was reviewed by a registered nurse.  A registered nurse completes an assessment of the resident following any adverse event. In the accident and incident forms reviewed, neurological observations had been completed following falls, but not at the frequency or for the timeframe required by the organisational policy. | i) Four of four behaviour monitoring forms in use for residents in the dementia unit were not fully completed and there was no documented evidence of review by a registered nurse.  ii) Three of eight files sampled (two rest home and one hospital) did not have the monitoring of food and fluid intake recorded at each meal as required by the care plan. | (i) Ensure that all sections of the behaviour monitoring form are fully completed and the behaviour monitoring form is reviewed by a registered nurse.  (ii) Ensure that the monitoring detailed in the care plan is completed.  60 days |
| Criterion 1.4.1.1  Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. | PA Moderate | Safety data sheets are provided to staff for the cleaning chemicals used on-site. Staff have attended training on chemical safety. Locked storage areas are available for the safe storage of chemicals.  One shower in the dementia unit also contains a sink for the cleaner to use. This sink has a cleaning dispensing unit in it that can be accessed by the resident’s. The staff interviewed advised that this shower door is kept locked when not in use. On two occasions during the audit, this shower door was found unlocked. | One shower in the dementia unit also contains a sink for the cleaner to use. This sink has a cleaning dispensing unit in it that can be accessed by the resident’s. The staff interviewed advised that this shower door is kept locked when not in use. On two occasions during the audit, this shower door was found unlocked. | Ensure that all chemicals are stored securely.  30 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Low | A maintenance person is employed 20 hours per week to undertake scheduled and planned maintenance. The general manager and clinical operations manager coordinate maintenance requests when the maintenance person is not on-site. There are essential contractors available over the 24-hour period. A number of outstanding maintenance issues were noted during the audit. Corrective action plans have been documented to rectify the outstanding issues but as yet have not been actioned. | A number of outstanding maintenance issues were noted during the audit. Specifically a) two showers in the dementia unit have cracked and crumbling shower linings and one shower has cracked lino; b) the floor under the commercial washing machine (that is raised off the floor) has exposed unsealed concrete underneath the machine; c) there is an area of flaky paint on the ceiling above the commercial dish washer in the kitchen; d) the cupboard and draws under the kitchen sink in the dementia unit have exposed and swollen timbers and the formica on the bench top is very worn; e) the bench under the hand basin in room 78 has exposed wood and the timbers have swollen; f) a number of doors and skirting have chipped paint; g) the carpets are dirty in the main dining room and in the hallways and the carpet in the entrance of the dementia unit smells of stale urine. | Ensure that all outstanding maintenance issues are addressed.  180 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Quality data is regular collected and collated. Run charts assist the clinical operations manager when analysing data. Results are regularly shared with staff in staff meetings and via graphs placed in the staff room each month. The implementation of a falls prevention programme has significantly reduced the number of falls for hospital level residents. | Hospital falls have reduced significantly over the past two years. During 2015, there was an average of 9.7 falls/month/1000 bed days. For the year ending 2016, there was an average of 4.45 falls/month/1000 bed days. Falls prevention strategies have included regular toileting, regular and frequent monitoring of residents who are at risk of falling and increasing staff awareness. The clinical operations manager remarked that a competition was initiated in 2016 between their two aged care facilities that worked well to increase staff awareness. Falls data is posted in the staff room each month. The staff reported that they work closely as a team to ensure that residents’ falls are kept to a minimum. The clinical operations manager reported that falls have also reduced significantly in the dementia unit but run chart results were skewed due to one identified frequent faller. |

End of the report.