

Warkworth Hospital Limited

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 Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Warkworth Hospital Limited

Premises audited: Warkworth Hospital

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

Dates of audit: Start date: 18 June 2015 End date: 19 June 2015

Proposed changes to current services (if any): At the request of the Ministry of Health four bedrooms were reviewed for use as either rest home or hospital level care (dual service) bringing the total of such beds to 10.

Total beds occupied across all premises included in the audit on the first day of the audit: 36



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Warkworth Hospital provides rest home and hospital level care for up to 36 residents. There were 36 residents on the first day of this audit.

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, review of a sample of resident and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

Residents and family members interviewed were positive about the care provided.

There are nine areas requiring improvement relating to one aspect of consumer rights, gaps in quality & risk documentation, analysis of data, corrective actions, current restraint competency for clinical staff, resident documentation, medication management, enabler documentation, and review of the infection control programme.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. This information is brought to the attention of residents' (if able) and their families on admission to the facility. Residents interviewed confirmed their rights were met, apart from the right to auditory privacy. Staff are respectful of residents' needs and communication is appropriate.

Residents and family interviewed confirmed consent forms are provided. They also confirmed they are given whatever information they require prior to giving informed consent. Residents and family also advised that time is provided if any discussions and explanation are required.

The facility manager is responsible for management of complaints and a complaints register is maintained.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Warkworth Hospital Limited is the governing body and is responsible for the service provided at this facility. Planning documents reviewed included a strategic plan, a risk and hazard management plan, and a mission statement and philosophy.

The facility manager is a registered nurse and is appropriately qualified and experienced. The facility manager is assisted by two senior registered nurses who oversee the day to day care of the residents. Support is also provided by an operations manager.

There was evidence that quality improvement data has been collected, collated and graphed, however not all data is being analysed for trends and corrective action plans developed and implemented. There is an internal audit programme in place, but the programme is not always followed, and documentation is not fully completed, dated with timeframes. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resource management. Staff records reviewed provided evidence human resource processes have been followed. Staff education records confirmed in-service education is provided. Clinical staff do not have current competencies for restraint management. The validation of current annual practising certificates for health professionals who require them to practice has occurred.

A documented rationale for determining staffing levels and skill mix was reviewed. The minimum number of staff on duty at any one time is one to two registered nurses and two caregivers. The facility manager is available after hours if required. Care staff, residents and family reported there is adequate staff available.

Resident information is entered into a register in an accurate and timely manner.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service's policies and procedures provide guidelines for access to the service. Initial assessment, care and support is provided by competent staff, however, initial care plans were not developed on admission, and long term care plans did not reflect all assessment information. Staff utilised information provided in the assessments to guide care. There was no documented evidence of input from residents and families in the development of care plans. Ongoing evaluations are completed by a registered nurse.

There is a broad range of activities which are appropriate for the service users. Residents and families interviewed confirm they are well supported to maintain interests and participation is voluntary.

The service has a documented medication management system, however there was evidence that nurses were transcribing 'as required' medications and indications for use were not consistently documented. There is also a requirement to ensure that staff follow correct procedure for medication administration.

Nutritional needs are met. Special dietary requirements are catered for and regular monitoring completed. Food services and storage meet food safety requirements.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All resident bedrooms provide single accommodation apart from two double rooms that provide appropriate privacy. All bedrooms have a wash hand basin and a number also have a toilet. Residents' rooms were observed to be of a good size and adequate personal space is provided in bedrooms. Lounges, dining areas and various other alcoves are available for residents to sit. External areas are available for sitting and shading is provided. An appropriate call bell system is available and security systems are in place. Sluice facilities are provided and protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is washed on site and cleaning and laundry systems include appropriate monitoring systems are in place to evaluate the effectiveness of these services.

The preventative and reactive maintenance programme includes equipment and electrical checks.

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.		Some standards applicable to this service partially attained and of low risk.
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There are no restraints used in the facility. There are documented guidelines for the use of restraint, enablers and challenging behaviours. Staff demonstrated an understanding of the appropriate use of enablers to maintain independence, however there was

no documented evidence of staff competencies. Enablers were in use, however, there was no documentation to demonstrate enabler use.

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.		Some standards applicable to this service partially attained and of low risk.
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Infection prevention and control policies and procedures are adequately documented. There is a designated infection control coordinator who is responsible for ensuring monthly surveillance is completed and monitoring of infection control practices. Documentation sighted provided evidence that all staff are educated as part of an initial orientation and as part of ongoing in-service education. An annual review of the infection control programme had not been completed.

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	38	0	4	3	0	0
Criteria	0	84	0	4	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Staff have received training on the Code in 2014.</p> <p>Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code was implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</p> <p>The information pack provided to residents on entry includes how to make a complaint and advocacy information.</p> <p>The auditors noted care staff displaying respectful attitudes towards residents and family members.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they</p>	FA	<p>Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The facility manager reported informed consent is discussed and recorded at the time the resident is admitted to the facility. Staff</p>

<p>need to make informed choices and give informed consent.</p>		<p>interviewed demonstrated a good understanding of informed consent processes.</p> <p>Residents / family are provided with various consent forms on admission for completion as appropriate and these were reviewed on resident's files. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained in the resident's file where residents have named EPOAs and these were reviewed.</p> <p>Residents and family interviewed confirmed they have been made aware of and understand the principles of informed consent, and confirmed informed consent information has been provided to them and their choices and decisions are acted on.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The facility manager advised an advocate from the Health and Disability Commissioners office visits. During these visits the advocate meet with residents and provides education for staff.</p> <p>Care staff interviewed demonstrated an understanding of how residents can access advocacy/support persons. Residents and family interviewed confirmed that advocacy support is available to them if required. They also confirmed this information was included in the information package they received on admission. Observations provided evidence the nationwide advocate details are displayed along with advocacy information brochures. Admission / pre-admission information was reviewed and provided evidence advocacy, complaints and Code of Rights information is included.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Visitors' policy and guidelines are available to ensure resident safety and well-being is not compromised by visitors to the service (for example, visitors are required to sign in and out via registers). The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs.</p> <p>Residents and family members interviewed confirmed they can have access to visitors of their choice, and confirmed they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van is available to take residents on community visits. Residents are encouraged to be involved in community activities and to maintain family and friends networks.</p> <p>Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The facility manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register was maintained that included verbal complaints and was reviewed during this audit.</p> <p>The facility manager advised there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, district health board (DHB), Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrated an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues they have during these meetings. This was confirmed during interview of residents and family and review of resident meeting minutes.</p> <p>Observations provided evidence that the complaint process was readily accessible and/or displayed. Review of staff meeting minutes provided evidence of reporting of complaints to staff. Care staff interviewed confirmed this information is reported to them via the staff meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The Code of Rights and information on the advocacy service are available and displayed at the facility. This information is provided as part of the pre-admission and information packs. The pre-admission and admission information was reviewed and contain, but are not limited to, information on the Code, advocacy and complaints processes. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to the resident's admission. Residents and family interviewed confirmed explanations regarding their rights occurred on admission. They also confirmed care staff provided them with information on their rights any time they have had a query.</p> <p>Families and residents are informed of the scope of the services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</p> <p>Residents interviewed confirmed they had access to an advocate if needed. The facility manager advised that the Health and Disability Commissioner advocate visits as needed. Residents' meetings are held monthly and the meeting minutes indicate residents are aware of their rights. The completed resident survey questionnaires indicates residents are aware of their rights and are satisfied with this aspect of service delivery.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>PA Low</p>	<p>Residents were observed being treated with respect by staff during this audit. This was confirmed during interviews of residents and family. Residents and family interviewed stated they attend church services as they choose. Education was provided to staff in June 2014 and staff interviewed confirmed this.</p> <p>Apart from two bedrooms that provide double accommodation, all other bedrooms provide single accommodation. The double rooms have appropriate curtaining for privacy and staff were observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff interviewed demonstrated an awareness of residents' rights and the maintenance of professional boundaries. During the audit there was a resident who was displaying auditory behaviour that was disturbing to other residents. Documentation reviewed, interviews of residents, and staff confirmed this. The auditors also observed this behaviour during the two days on site.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The organisation has a Māori health plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.</p> <p>There are currently three residents and one staff who identify as Māori. Access to Māori support and advocacy services is available if required from a Kaumatua in the local community and the DHB. The staff member also acts as an advisor and speaks Te Reo.</p> <p>Specific cultural needs were not identified in the residents' care plans reviewed (see criterion 1.3.4.2).</p> <p>Staff are aware of the importance of whanau in the delivery of care for the Maori residents. Cultural safety education is provided as part of the in-service education programme. Whanau are able to be involved in the care of their family members.</p> <p>Care staff interviewed demonstrated an understanding of cultural safety in relation to care. They also confirmed that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe</p>	<p>FA</p>	<p>Documentation lists the details on how to access appropriate expertise including cultural specialists and interpreters.</p> <p>Residents' files demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details.</p>

<p>services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>Residents interviewed confirmed their culture, values and beliefs are being respected, and their spiritual needs are met, however, care plans reviewed did not record resident's cultural spiritual, values and beliefs (see criterion 1.3.4.2).</p> <p>During interviews care staff demonstrated an understanding of cultural safety in relation to care. Staff also demonstrated processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Policies and procedures outline the safeguards to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies and procedures and staff files reviewed included code of conduct information that all staff are required to adhere to. These documents also address any conflict of interest issues including the accepting of gifts and personal transactions with residents. Expected staff practice is also outlined in job descriptions and employment contracts.</p> <p>A review of the accident/incident reporting system, complaints register and interview of the facility manager indicate there have been no allegations made by residents alleging unacceptable behaviour by staff members. Residents and family interviewed reported that staff maintain appropriate professional boundaries. Care staff interviewed demonstrated an awareness of the importance of maintaining boundaries and processes they are required to adhere to.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. Documentation reviewed provided evidence that policies and procedures are based on evidence-based rationales.</p> <p>Education is provided by specialist educators as part of the in-service education programme which is overseen by the facility manager. The district health board (DHB) and other external agencies also provide education as part of the in-service education programme. The facility manager described the process for ensuring service provision is based on best practice, including access to education by specialist educators. Staff interviewed confirmed an understanding of professional boundaries and practice.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed provided evidence that communication with family members is being documented in residents' records. (Refer 1.3.4.2)</p>

<p>provide an environment conducive to effective communication.</p>		<p>Residents and family interviewed confirmed that staff communicate well with them. Residents interviewed confirmed that they are aware of the staff that are responsible for their care.</p> <p>The facility manager advised access to interpreter services is available via staff, family and the local community if required. They also advised there are currently no residents who require interpreter services.</p> <p>The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Warkworth Hospital Limited is the governing body and is responsible for the service provided at Warkworth Hospital. A strategic plan and a risk and hazard management plan were reviewed and included goals and objectives. A mission statement, values, vision and objectives were also reviewed. There is evidence of monitoring and review of the goals in the business plan. The facility is at 100% occupancy with a waiting list.</p> <p>The facility manager provides monthly reports to the two directors and these were reviewed. The reports include but are not limited to reporting on: staffing; new business; daily bed status; event data; and any issues.</p> <p>The facility manager is a registered nurse who has been in this position since 2006. The facility manager (FM) is responsible for the day-to-day management of the facility as well as for the oversight of clinical care with support from two senior registered nurses. The annual practising certificate for the FM was sighted and is current. There was evidence on the FM's file of ongoing education.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>Warkworth Hospital is currently certified to provide 36 rest home and hospital level care beds. There were 27 hospital and nine rest home residents during this audit.</p> <p>The service provider has funding contracts with the district health board (DHB) and Ministry of Health to provide aged related residential care services, residential care (non-aged), and long term support – chronic health conditions- residential.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-</p>	<p>FA</p>	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager (FM) be absent. Either of the two senior RNs fill in for the FM if they are absent for clinical governance. The operations manager fills in for other responsibilities that are non-clinical when the FM is absent. The operations manager confirmed their responsibility and authority</p>

<p>to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>for this role.</p> <p>Services provided meet the specific needs of the resident groups within the facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>A quality, risk and hazard management plan was reviewed along with a strategic plan. These are used to guide the quality programme and include goals and objectives.</p> <p>The facility manager is responsible for oversight of the internal audits and the in-service education programme. Completed internal audits for 2015 were reviewed. There are gaps in the internal audit programme and completed audits. Audits for 2013 were sighted, however, audits for 2014 were not available.</p> <p>Risks are identified and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual is available that includes relevant policies and procedures.</p> <p>Monthly RN and resident meetings are held and staff meetings are held two monthly. Meeting minutes reviewed provided some evidence of reporting / feedback on completion of internal audits and various clinical indicators. Although data is being collected, collated and graphed, apart from data relating to infection control, there is little evidence of data being analysed to identify trends.</p> <p>Internal audits provide evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed. Corrective actions, timeframes and who is responsible for the corrective action and sign off is not evidenced in the RN and staff meeting minutes and only some actions are developed and implemented in the residents' meeting minutes.</p> <p>Relevant standards are identified and included in the policies and procedures manuals. Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward</p>	<p>FA</p>	<p>Staff document adverse events on an event form and these are reviewed by the facility manager and signed off. This data is collated at the end of each month. The analysis of this data is basic and requires further development (see criterion 1.2.3.6). Resident's files evidenced individual event</p>

<p>events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>monitoring chart/register is kept. A monthly event form is completed with graphing of falls, skin tears, bruising.</p> <p>There is an open disclosure policy. Residents' documentation reviewed provided evidence of communication with families/next-of-kin/enduring power of attorney (EPOA) following adverse events involving the resident, or any change in the resident's condition.</p> <p>Staff confirmed they are made aware of their notification responsibilities through job descriptions and policies and procedures, which was confirmed by review of documentation. Policy and procedures comply with essential notification reporting. The facility manager advised there had been no notifications of significant events made to external agencies.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, completed orientations and competency assessments (as appropriate). Copies of current annual practising certificates were reviewed for all staff and contractors that require them to practice.</p> <p>The facility manager is responsible for the in-service education programme. The education planners for 2014 and 2015 were reviewed and education is provided at least monthly. Individual staff attendance records and attendance records for each education session are held electronically and were reviewed and provided evidence ongoing education is provided. Competency assessment questionnaires were available and completed competencies were reviewed for medication management.</p> <p>An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. Orientation for staff covers the essential components of the service provided and the competency of staff is reviewed following completion. The facility manager confirmed this.</p> <p>Care staff interviewed confirmed they have completed an orientation, including competency assessments (as appropriate).</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. There is at least one RN on duty at all times. On call after</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>hours registered nurse support and advice is provided by the facility manager. The minimum amount of staff on duty is during the night and consists of one to two RNs and two caregivers.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. Current first aid certificates were sighted for all RNs. Residents and family interviewed reported staff provide them with adequate care.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Resident information is entered in an accurate and timely manner into a register on the day of admission. Resident files are integrated and recent test/investigation/assessment information is located in residents' files. Approved abbreviations are listed. Resident files reviewed provided evidence that entries into the residents' clinical record include the date, but not the time of the entry (see criterion 1.2.3.1).</p> <p>Residents' information is stored in a staff area and held securely and not on public display. Clinical notes are current and accessible to all clinical staff. Individual resident files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder with medication. The resident's national health index (NHI) number, name, date of birth and GP are used as the unique identifier.</p> <p>Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information. Historical records are held securely on site and accessible.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Entry to service guidelines are clearly documented in service policy, and processes are implemented to ensure resident's entry to the service is facilitated in a competent, equitable, timely and respectful manner. Resident's orientation documents ensure residents are given sufficient information. Residents and family members interviewed confirmed they have been fully informed during all processes. A review of clinical files confirmed the needs assessments have been completed. Signed and dated admission agreements were sighted and staff interviews verified the processes which ensure residents receive the necessary prescribed care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p>	<p>FA</p>	<p>Policy and procedures, and the RN confirmed the correct processes are followed around exit and discharge. Referral information provided to other service providers was sighted in clinical files and copies of correspondence retained.</p>

discharge, or transfer from services.		
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>There are documented policies and procedures for medication management. Administration records are maintained. Interviews with staff and a review of staff files confirmed that only staff who have been assessed as competent are responsible for medication management. Medication trolleys and cupboards are locked, with the keys being held by the staff member responsible for medications on the day. All charts include photo identification and any allergies identified. Three monthly GP reviews are evident. Individually prescribed medications are used and a blister pack system utilised. There is one controlled drug locked safe and controlled drug logs are maintained with evidence of regular reconciliation sighted. A medication fridge temperature monitoring is completed daily. Residents are prescribed medication that could be used as required. There were no residents who self-administer medications. There have been no adverse events related to medication management.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Residents are provided with a well-balanced diet which meets nutritional requirements. Kitchen staff confirmed that there is dietitian input into the menu and the relevant report confirming this was sighted. A six weekly menu is followed and the meals provided on the day were in line with the menu sighted. Residents interviewed were satisfied with the meals provided.</p> <p>Dietary assessments are completed on admission and special dietary requirements are highlighted and recorded on documents held in the kitchen. Individual food preference lists were sighted and allergies identified. Kitchen staff have the required food safety qualifications. The kitchen is well stocked, clean and tidy. Fresh fruit and vegetables and other food stuffs are stored appropriately. There is evidence of temperature monitoring for food, fridge and chiller, and maintenance of a cleaning schedule.</p> <p>Labels and dates are on all containers, and food in the chiller is covered and dated. There have been no reported incidents of residents becoming unwell as a result of poor food handling practices.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>Organisational policies provide guidelines around declining entry to the service. There was no evidence of potential residents being declined entry. Clinical staff confirmed new residents were accepted into care following referral from the needs assessment service co-ordinator (NASC).</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>Clinical staff confirmed assessment information was used to guide initial care. Residents and families interviewed confirmed their involvement in the assessment process. Interviews with clinical staff confirmed that assessment is an ongoing process. Long term care plans were developed with identified goals. Care plans were evaluated in a timely manner and updated as necessary to reflect current resident needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long-term and short-term care plans are developed and include goals, however these were not consistently completed (Refer 1.3.4.2) Clinical staff interviewed confirm access to resident files and completion of daily progress notes demonstrate prescribed care is completed. There is evidence of other support services within the care plan process, for example, specialist input. Residents observed have the necessary prescribed equipment to minimise risk and to promote independence. The GP described an effective working relationship with staff, and confirmed continuity of service delivery.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Short term care plans are developed as required, for example, for one resident who recently developed an infection, however this was not done consistently (Refer 1.3.4.2) Documentation completed daily by care staff confirms care is being completed as prescribed. Handover sheets demonstrate that clinical staff discuss the needs of individual residents on a daily basis. The GP has confidence that interventions are implemented in an appropriate and timely manner.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities are facilitated four days per week. Activities are planned one month in advance and include a variety of activities appropriate to resident needs. Residents interviewed confirmed a high degree of satisfaction with activities and outings provided, and confirmed participation is voluntary. Support is provided for individuals to attend activities specific to their needs with one to one support as necessary. Residents were observed participating in the days planned activity, they were supported and appeared to be enjoying the activity. Participation records are maintained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>A policy describes the evaluation process. Files sampled include evaluations. They are conducted regularly and describe the degree of achievement and progress towards meeting desired outcomes. Evaluations sighted show clear links to the care plan. The RN initiates changes to the plan of care where progress is different from expected, however, this was not done consistently (Refer 1.3.4.2). Family members confirmed a high level of satisfaction with the service.</p>

<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Interviews with clinical staff, GP and family members confirmed that residents are provided with access to other service providers as required. Files demonstrate links via a referral process with external health professionals, for example, acute care hospitals, wound care specialist. Care plans have been adapted as necessary to include specialist care and advice.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes are in place for the management of waste and hazardous substances including specifying labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Education on chemical safety is provided as part of the staff in-service education programme. Staff interviewed reported they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Observations provided evidence hazardous substances were correctly labelled, the containers were appropriate for the content including container type, strength and type of lid/opening. Three sluice facilities are provided for the disposal of waste. Protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substances being handled are provided and being used by staff. For example, gloves, aprons, and visors were sighted in the sluice rooms.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The operations manager has oversight of the maintenance programme. External contractors are used for plumbing, electrical and other specialist areas. There is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Calibration reports for medical equipment were reviewed along with electrical safety tags on electrical items. Documentation and observations evidenced a current building warrant of fitness is displayed that expires 17 July 2015.</p> <p>Observations of the facility provided evidence of safe storage of medical equipment. Corridors are wide and residents were observed to be safely passing each other; safety rails are secure and are appropriately located.</p> <p>External areas are available for residents and these are maintained to an adequate standard and are appropriate to the residents in Warkworth Hospital. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating and shade; and ensuring</p>

		<p>a safe areas are available for recreation or evacuation purposes.</p> <p>Care staff confirmed they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.</p> <p>Residents confirmed they know the processes to follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>All bedrooms have wash hand basins and 16 have toilets facilities. There are adequate number of accessible communal showers, toilets and wash hand basins for residents. Toilets and showers are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored two weekly and are maintained at a safe temperature.</p> <p>Toilets have appropriate access for residents based on their needs and abilities. Communal toilets and showers have a system that indicates if it is vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>With the exception of two double bedrooms, all bedrooms provide single accommodation. All rooms are large and have one and a half doors and adequate personal space is provided in bedrooms to allow residents and staff to move around safely. Rooms are personalised to varying degrees. An addition of four bedrooms was reviewed that are able to be used for rest home or hospital level care. These rooms are large and have one and a half doors and adequate personal space is provided to allow residents and staff to move around safely and to use any equipment.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p>	FA	<p>Adequate access is provided to the lounges, sitting areas and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.</p>

needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.</p> <p>All linen is washed on site and there is adequate dirty / clean flow. Laundry staff are responsible for management of laundry. Staff described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed.</p> <p>Observations provided evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; appropriate facilities exist for the disposal of soiled water/waste (i.e., sluices), convenient hand washing facilities are available, and hygiene standards are maintained in storage areas.</p> <p>Residents and family interviewed stated they were satisfied with the cleaning and laundry service and this was also confirmed during the review of the satisfaction survey questionnaires.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Documented systems are in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification are available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors are available.</p> <p>A New Zealand Fire Service letter dated 24 July 2006 was reviewed and confirmed the fire evacuation scheme is approved. The last trial evacuation was held on 5 May 2015.</p> <p>There is at least one staff member / RN on duty with a current first aid certificate. Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.</p> <p>Observations provided evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. Observations evidenced emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.</p> <p>There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within</p>

		reach, and available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Procedures are in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family interviewed confirmed the facility is maintained at an appropriate temperature.</p> <p>Observations evidenced that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	PA Low	<p>An RN is the designated infection control coordinator. The coordinator confirmed that a surveillance programme is maintained. Surveillance data was sighted and included infection details related to clinical files sampled. Monthly analysis is completed. Reports are provided for monthly clinical team meetings. A review of clinical files and medication charts showed antibiotics are prescribed only if clinically indicated.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>Staff were observed to complete hand hygiene and used personal protective equipment appropriately. An outbreak kit was sighted and accessible and appropriately stocked. Hand sanitizers are readily available to residents, staff and visitors. Resident rooms have hand basins. Staff are able to identify infection control personnel. There have been no outbreaks.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are</p>	FA	<p>Policies and procedures are available and the infection control coordinator is able to demonstrate that available external resources are utilised to ensure current best practice. Documentation was sighted to confirm this and included a plan of care for a resident with an infection.</p>

readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Education has been provided to staff by the clinical manager around infection control and is also included in the orientation process. Training sessions are documented and attendance records completed.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control coordinator confirmed a surveillance programme is maintained. Surveillance data was sighted and included infection details related to files sampled. Infections have been analysed monthly with comprehensive reports written. Reports have been presented and discussed at staff meetings. The infection control surveillance is appropriate to the size of the service.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	PA Low	A restraint policy is appropriate for this service. Restraints are not used in the facility. Staff are provided with education on restraint minimisation and challenging behaviour. Staff described enablers as being voluntary as per the policy and the policy defines both enablers and restraints.

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.3.1</p> <p>The service respects the physical, visual, auditory, and personal privacy of the consumer and their belongings at all times.</p>	PA Low	<p>Staff interviewed displayed good knowledge of resident’s rights. Residents and family confirmed their belongings are also respected by staff.</p> <p>There was a resident displaying behaviour throughout the two days the auditors were on site who was disturbing other residents. This resident has been reassessed by the NASC team prior to being transferred to this facility. Residents spontaneously complained about the disruptive behaviour. Review of this resident’s file showed entries in the care plan and progress notes concerning this behaviour. Staff reported that this resident’s behaviour has slowly become more continuous and louder over the short time they have been in this facility.</p>	A resident’s frequent disruptive behaviour is having an effect on other residents and staff.	<p>Provide evidence that this resident is reassessed with a view to being placed appropriately.</p> <p>180 days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management</p>	PA Moderate	A quality, risk and hazard management plan was reviewed. Staff interviewed had knowledge of the internal audit programme and reported they discuss quality and risk at their staff meetings. Audits for 2015 and 2013 were reviewed, however, audits for 2014 were not available. The internal audit programme was reviewed and medicine management and restraint audits are not included in the	The audit programme does not include all areas of	Provide evidence that the audit programme includes all

system which is understood and implemented by service providers.		programme, and as a result these areas of service have not been audited. Most audits for 2015 reviewed have been completed in the last month.	service delivery. Completed audits are not consistently completed fully.	necessary audits; that audits are completed as per the programme and that documentation is fully completed and dates and times recorded. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Review of quality improvement data shows it is being collected, collated and graphed. Infection prevention and control data is being analysed and trends identified. Minutes of RN meetings provide evidence that this data is communicated back to staff. Other quality data is not being analysed to identify trends and reported back to staff. Interview of staff confirmed this.	Quality improvement data apart from infection prevention and control data is not being analysed to identify trends.	Provide evidence that all quality improvement data is analysed to identify trends and is communicated back to staff. 90 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is	PA Moderate	Audits reviewed have corrective action plans developed and implemented and have been evaluated. Infection prevention and control documentation reviewed provided good evidence of corrective actions by the infection control coordinator. This information was attached to the RN meeting minutes reviewed and the infection control coordinator at interview reported this data is reported back to staff at the meetings and staff confirmed this. Minutes of staff meetings reviewed show corrective actions are not consistently documented. Timeframes for completion of corrective actions, who is	Corrective action plans are inconsistently developed, implemented, monitored and evaluated to	Provide evidence that corrective action plans are being developed implemented, monitored and

developed and implemented.		responsible for the action and date of closure, is not recorded. Resident meeting minutes show some corrective actions are developed and implemented. However, those issues raised by residents where the corrective action is the responsibility of others rather than the activities person who takes the minutes are being brought forward month after month and there is no evidence of corrective actions being addressed.	address areas requiring improvement as a result of issues raised on RN, staff and resident meetings.	reviewed to address areas requiring improvement as a result of issues raised at RN, staff and resident meetings. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The operations manager reported they have developed a spread sheet that documents staff education and competencies. Review evidenced individual education completed by staff at least monthly and current medication competencies. The facility manager reported they were not aware that clinical staff had to complete restraint competencies because there are no residents who are currently using restraint residing in the facility.	Competency assessments for restraint were not available for clinical staff.	Provide evidence that clinical staff complete competency assessments for restraint and that the competencies remain current. 180 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and	PA Moderate	i)All clinical files sampled showed nurses were transcribing medications to use as required. ii)All clinical files sampled had medications to use as required, however, there were no indications for use. iii)There was no evidence of prescribing doctors specimen signatures. iv)A staff member was observed to sign for medication administration before administration.	i)Nurses were transcribing medications. ii)Medications to use as required did not consistently have documented indications for	i)Nurses are not to transcribe medications. ii)The prescribing doctor must provide indications for use for medications to

<p>medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>			<p>use. iii)There were no specimen signatures for prescribing doctors. iv)Staff did not follow correct medication administration procedure.</p>	<p>use as required. iii)Record specimen signatures for prescribing doctors. iv)Staff to follow correct medication administration procedure. 90 days</p>
<p>Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Moderate</p>	<p>Six of six clinical files included assessments completed on admission, however there were no initial care plans. Six of six clinical files contained long term care plans which identified actual problems (Refer 1.3.5). Two of six clinical files identified falls risk and pressure area risk on admission. Two of six clinical files included assessment information and short term care plans where progress was different from expected (Refer 1.3.8). There was no documentation to show residents or family had been involved in the development of care plans. Three clinical files contained next of kin communication documents which evidenced discussions held. Six clinical files contained a document with signatures of multidisciplinary team members and family/whanau to verify a six monthly review of residents needs had been completed. The GP had documented outcome of discussion held with resident or family/whanau, pertaining to role of medical practitioner.</p>	<p>i)Initial care plans were not developed on admission. ii)Long term care plans were not comprehensive and did not reflect all assessment information. iii)Four residents did not have the required risk assessments completed on admission. iv)Four clinical</p>	<p>i)Develop initial care plans on admission. ii)Ensure initial and long term care plans reflect all aspects of assessment information. iii)Ensure ongoing assessment information is documented and short term care plans are developed where progress is different from</p>

			<p>files did not include documented assessment outcomes or short term care plans to reflect assessed needs.</p> <p>v)There was no documented evidence that residents or family had been involved in the development of care plans.</p> <p>vi)Three clinical files identified concerns with no evidence families had been notified.</p>	<p>expected.</p> <p>iv)Document evidence that resident or family have been involved in the development of initial and long term care plans.</p> <p>v)Document discussions held with family to demonstrate information sharing on an ongoing basis including six month review process.</p> <p>90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	<p>PA Low</p>	<p>There was no evidence that an annual review of the infection control programme had been completed.</p>	<p>There has not been an annual review of the infection control programme.</p>	<p>Complete an annual review of the infection control programme.</p> <p>180 days</p>

<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>PA Low</p>	<p>Two residents were observed to be using bedrails as enablers. The relevant clinical files had no evidence of an enabler assessment or monitoring being completed. Care plans did not include enabler use. There was a restraint/enabler register, however, it was not current.</p>	<p>There is no documentation in relation to enabler use and the register does not record current enablers in use.</p>	<p>Provide evidence of documentation relating to enablers and current register of enablers used at the facility.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.