# Castlewood Nursing Home Limited - Castlewood Nursing Home

## Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Castlewood Nursing Home Limited

**Premises audited:** Castlewood Nursing Home

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

**Dates of audit:** Start date: 11 November 2015 End date: 12 November 2015

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 22

# 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

This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. Castlewood Nursing Home (referred to as Castlewood Home) can provide care for up to 24 residents.

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

The manager is responsible for the overall management of the facility along with the owner. Clinical support and oversight is provided by the two registered nurses.

Improvements are required to the following: advance directives; resident records; development of policies; care planning; activity programme; medication processes; human resources processes and infection control.

## Consumer rights

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

Staff are able to demonstrate an understanding of residents' rights. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service has a documented and implemented complaints management system. Documentation of advance directives should be reviewed.

## Organisational management

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

The organisation's mission statement and vision is documented. There is a current business plan and quality and risk management plan. Quality and risk management systems support service delivery and include internal audits, complaints management, resident and relative satisfaction surveys, and incident/accident management. Quality and risk management activities and results are shared among staff, residents and family, with the owner and manager driving quality improvement. Policies have been reviewed in 2015 however some require further development and some policies require documentation.

Human resource policies include recruitment information, selection, orientation, staff training and development. Referee checks, criminal vetting and monitoring of annual practicing certificates for health professionals occurs. Staffing levels meet occupancy and acuity levels and residents state that they have adequate access to staff when needed.

An improvement is required to resident records.

## 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. |

There is evidence that each stage of service provision is developed with resident and/or family input. The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices.

A sampling of residents' clinical files validated the service delivery to the residents. Timeframes of service delivery need to be adhered to and assessments need to be completed. Long term care plans are individualised and record the required interventions. Short term care plans need to be completed for short term problems.

The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis. The activities programme needs to record all activities that are provided. The activities care plans are to record the interventions required to meet the activities care goals.

Staff responsible for medicine management attend medication management education and have current medication competencies. Medication management systems around prescribing, storage, filing and residents’ photos require improvement. There is a policy on residents’ self-administering medicines, however this requires to be adhered to.

There is a central kitchen and on site staff that provide the food service. Residents’ dietary profiles are completed, however this information needs to be communicated to kitchen staff. Menu review by a dietitian has been completed, however the corrective actions post review are yet to be actioned. Food service management around food storage, kitchen cleaning and monitoring of appliance temperatures requires improvements.

## 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. |

All building and plant comply with legislation, with a current building warrant of fitness in place. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

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

## Restraint minimisation and safe practice

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

Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were no residents using restraint or enablers on audit days.

## 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. |

The infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. New employees are provided with training in infection control practices and there is on-going infection control education available for all staff. The infection control programme requires annual review.

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

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 34 | 0 | 3 | 8 | 0 | 0 |
| **Criteria** | 0 | 79 | 0 | 5 | 9 | 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 Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility. New residents and families are provided with copies of the Code as part of the admission process.  Staff have had training around rights and the Code in 2015. Staff were observed to implement rights as per the Code in their day-to-day practice. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | The service information pack includes information regarding informed consent. The registered nurse discusses informed consent processes with residents and their families/whānau during the admission process. Staff confirmed their understanding of informed consent processes.  The informed consent policy and procedure directs staff in relation to gaining informed consent. This included guidelines for consent for resuscitation/advance directives. Staff ensure that all residents are aware of treatment and interventions planned for them, and that the resident and/or significant others are included in the planning of that care.  All resident files identify that the required consents are collected.  The general practitioner (GP) signs to state competence of the resident and the resuscitation status is ticked. There should be clarity around who is determining resuscitation status. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service.  Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.  Discussions with family and residents identifies that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files include information on resident’s family/whānau and chosen social networks. |
| 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 | There are no set visiting hours and family report that they are encouraged to visit at any time. Residents confirm that they are supported and encouraged to access community services with visitors or as part of the planned activities programme. The service also encourages the community to be a part of the residents’ lives with visits from entertainers.  Residents attend the medical centre for their medical checks as this encourages community engagement. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints. Complaints management is explained as part of the admission process for residents and is part of the staff orientation programme and ongoing education. Residents and family confirm that the management open door policy makes it easy to discuss concerns at any time.  The complaints register records the complaint, dates and actions taken. There were no outstanding complaints at the time of the audit and there have been no complaints to external authorities since the last audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The manager or registered nurse discusses the Code, including the complaints process, with residents and their family on admission. Discussions relating to the Code are also held at the resident meetings.  Information regarding the Health and Disability Advocacy Service is clearly displayed in the facility. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.  Residents and family confirm that their rights are being upheld by the service. They are able to describe their rights and advocacy services particularly in relation to the complaints process. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes dignity and respect and quality of life. Residents’ support needs are assessed using a holistic approach. The assessment process includes gaining details of people’s beliefs and values. Residents and family confirm that they are included in the care planning process and are addressed by their preferred name. Caregivers state that they support the residents' independence by encouraging them to be as active as possible.  A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner. This includes strategies to manage any behaviours of concern.  The residents’ own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room and there are areas in the facility which can be used for private meetings. Caregivers 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. This was observed on the days of the audit. Residents and families confirm that their privacy is respected.  Staff have had training around abuse and neglect in 2015 and are able to describe the reporting process should any be identified. Family, staff, residents and the general practitioners state that there is no evidence of abuse and neglect.  Residents are supported to access spiritual support when needed and there are interdenominational services at least weekly. |
| 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 implements the Māori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan. Links to local Māori are available through Ngai Tahu and through the manager who has personal contacts.  Any Māori resident living at the facility would have their cultural needs assessed with any preferences documented. Residents confirm that their cultural needs are well met. Staff are aware of the importance of family in the delivery of care for the Māori resident. All staff have received training on cultural safety. The manager states that there have not been any Māori residents who have required long term care in the service. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The service identifies each resident’s personal needs from the time of admission. This is completed with the resident, family and/or their representative having input into the admission, assessment and planning processes.  Residents determine when cares occur, times for meals, choices in meals and choices in activities. Caregivers described how they encourage residents to be as independent as possible. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff files have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. Families and residents expressed no concerns with breaches in professional boundaries, discrimination or harassment. Staff orientation and their employee agreement include standards of conduct. Interviews with staff confirm their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | There are policies and procedures to guide practice (refer 1.2.3.3). These align with the health and disability services standards. Policies are reviewed as changes in legislation occur and on an annual rolling schedule.  A staff training programme is implemented and staff can describe sound practice based on policies and procedures, care plans and information given to them via the registered nurses and general practitioner.  Consultation is also available with health professionals and specialists in the region with staff able to describe how and when they can make contact. Residents and families interviewed expressed a high level of satisfaction with the care delivered.  The medical centre is located next door to the service and staff state that they can access the general practitioner if required, with good support provided. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guided staff on the process to ensure full and frank open disclosure was available. Family members interviewed confirm that they are informed if the resident has an incident, accident, or has a change in health or needs. Family contact is recorded in residents’ files.  Interpreting services are available from the district health board. There were no residents requiring interpreting services at the time of the audit.  The information pack is available in large print and this could be read to residents. Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Castlewood Home has systems in place which record the scope, direction and goals of the service. Monthly management meetings are held between the registered nurse and the owner and there are monthly staff meetings which include quality and risk management issues, internal audit outcomes and clinical indicators.  The Castlewood Home philosophy is displayed at the entrance to the facility and there is a business plan 2015 documented that is reviewed annually by the owner. The owner is a registered nurse but no longer has a current practicing certificate.  The manager is employed full time and has been in the role in this facility for 16 years. The manager has completed the national certificate in rest home care and maintains at least eight hours annually of professional development activities relating to managing a rest home.  There are two registered nurses who job share working each three days one week and two days in the next week. Both have a current practicing certificate. One has been employed since March 2015 and has a background in surgical nursing with one year of experience in aged care. The second registered nurse has been with the service for six weeks and has completed the competency assessment programme level seven from Otago Polytechnic in 2015.  Castlewood Home has contracts with the Otago District Heath Board (DHB) for rest home services and aged related residential respite care. The facility can provide care for up to 24 residents requiring rest home level of care with 22 residents in the service on the days of the audit. |
| 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 | The diversional therapist is designated as second in charge with the diversional therapist having a sound understanding of the role. The role is documented. The registered nurses provide clinical support and advice. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | There is a quality and risk management framework that is documented to guide practice. There is a business plan and quality and risk management plan, with annual reviews documented. The manager completes reviews of each aspect of service delivery using a monthly audit schedule to ensure that all audits and reviews are completed thoroughly.  Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, surveillance of infections, implementation of an internal audit programme. Corrective action plans are documented and evidence of resolution of issues are documented when these are identified.  There are monthly staff meetings held that include all aspects of the quality programme. There are two monthly resident meetings with family able to attend if they choose to. A management meeting is held monthly with the owner present.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews, as required, with all policies having been reviewed last in 2015 with the manager and an external consultant (registered nurse) involved in the review. Policies are readily available to staff in hard copy in the office. Staff interviewed state that they read any new or revised policies and all sign a form indicating that they have read and understood policies. Further policy development is required.  All clinical staff interviewed report they are kept informed of quality improvements.  The organisation has a comprehensive risk management programme in place. Health and safety policies and procedures are in place for the service. There is a health and safety audit completed at least annually. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated.  There is an annual resident/family satisfaction survey and results documented from the 2015 survey indicate that residents and family are very happy with the service and environment with minimal suggestions for improvement.  Policies documented have been reviewed in 2015 with further development of these required. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | The manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, for example, unexpected deaths, critical incidents, infectious disease outbreaks.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process as evidenced in interviews with staff, the manager and diversional therapist.  Staff receive education at orientation on the incident and accident reporting process. Staff understand the adverse event reporting process and their obligation to document all untoward events.  Fifteen incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at the monthly staff meeting. There is some analysis of incidents and accidents that occurs monthly at staff meetings. |
| 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 | The registered nurses hold current annual practising certificates. The service monitors the annual practicing certificates of visiting health practitioners for example the general practitioner, dietitian and podiatrist.  Staff files included a signed contract, privacy and confidentiality forms and evidence of orientation including a 'buddy' checklist. There is an annual appraisal process in place with all staff having a current performance appraisal. First aid certificates are held in staff files along with other training records. Records of referee checks and criminal vetting are completed with documentation retained in staff files.  All staff undergo a comprehensive orientation programme that meets the educational requirements of the Aged Residential Care (ARC) contract. Caregivers are paired with a senior caregiver for shifts until they demonstrate competency.  Annual medication competencies are completed for all caregivers.  There is an annual training plan implemented and staff state that they find the training relevant to their needs with at least eight hours completed per year. Monthly training sessions are held for all staff. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a policy around staffing which is the foundation for work force planning. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.  The owner lives on site. There are two registered nurses who are on site during work hours on weekdays and both take turns at being on call. The manager is also on call. Staff confirm that the manager and/or registered nurse is available at any time and they respond immediately if rung.  There are 19 staff including the manager, diversional therapist and caregivers. Caregivers are rostered to take on other roles such as laundry services and cleaning.  Residents and families confirm staffing is more than adequate to meet the residents’ needs and residents and family members praised the staff and manager for support provided. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | PA Low | Information is entered into the resident information management system in an accurate and timely manner. Information of a private or personal nature is maintained in the nurse’s station but the cabinet is not able to be locked. Archived records are stored onsite.  Each resident has a file that includes assessment, planning and other information related to their care. Progress note entries are made by staff on duty as changes for the resident occur however progress notes are recorded in between one and five days. Records are legible and the name and designation of the staff member is documented most of the time. Improvements are required to frequency of entering progress notes, documentation of designation and date and security of resident records.  Resident information related to care is integrated. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Entry and assessment processes are recorded and implemented. Relevant information is available for residents and their family about the services provided at the facility.  Residents' admission agreements evidence resident and/or family and facility representative sign off. The admission agreement defines the scope of the service and includes all contractual requirements. The needs assessments are completed for rest home level of care. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect to resident care. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge or transfer is managed in a planned and co-ordinated manner. There is open communication between all services, the resident and the family. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medication storage, including controlled drug storage, confirmed an appropriate medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded. Medicine management systems require improvement around safety of medication storage, prescribing, filing and residents’ photos.  All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records were maintained, as were specimen signatures. Staff education in medicine management was conducted.  Medicine charts are typed by the pharmacist and some entries were handwritten by the GPs and were legible. Three monthly medicine reviews were conducted. The residents' medicine charts record all medications the resident is taking (including name, dose, frequency and route to be given). There was one resident self-administering medicines at the facility and this is required to be conducted as per policy. |
| 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. | PA Moderate | There is a four week, seasonal menu used at the facility that has been approved by a dietitian in March 2014. Not all the dietician’s recommendations for corrective actions following the menu review have been implemented. A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed, however this is not always communicated to kitchen staff.  Evidence of resident satisfaction with meals was verified by resident and family/whānau interviews. Interview with the cook confirmed the fridge, freezer and chiller temperatures are monitored, however these are conducted every second week. Food temperatures are recorded. Kitchen staff have completed food safety education. |
| 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 | There is a process for informing residents, their family/whānau and their referrers if entry to the service is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | On admission, residents have their needs identified through a variety of information sources that include: the Needs Assessment and Service Coordination (NASC) agency; other service providers involved with the resident; the resident and family/whānau.  The interRAI assessments are not completed at the facility. RN and management interviews confirmed the RNs are booked to undertake the interRAI training. The initial care planning process is not always fully completed. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Residents’ long term care plans are individualised, integrated and up to date. Care plan interventions reflect the risk assessments and the level of care required. In interviews, staff reported they receive adequate information for continuity of residents’ care. The residents have input into their care planning and review, evidenced in all the resident files sighted. Regular GP care is implemented and was sighted in current GP progress reports. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents. In interviews, both residents and family confirmed current care and treatments meet the residents’ needs. Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained (refer to criterion 1.2.9.1). In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated. |
| 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. | PA Moderate | Interview with the diversional therapist (DT) confirmed the monthly activities programme is recorded on the DTs planner. The weekly activities programme is written up on the information white board in the lounge. Not all activities provided are recorded on the DTs planner or the residents’ information white board. Activities include community activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. Residents’ meetings are conducted by monthly.  Residents are assessed to ascertain their recreational needs and appropriate activity and social requirements (refer to criterion1.3.3.3). The residents’ files evidenced the activities care plans record goals, however these are not consistently individualised and do not evidence the required interventions or six monthly reviews at the time the care plan is reviewed. The DT enters residents’ progress around activities in the activities progress notes three monthly. The DT monitors residents’ attendance at activities.  Interviews with residents confirmed satisfaction with the activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | Time frames in relation to care planning evaluations are documented. Residents' care plans were up-to-date and reviewed six monthly. In interviews, residents and family confirmed their participation in care plan evaluations.  In interviews with the manager, RN and GP it was confirmed when resident’s progress was different than expected; the GP is contacted, as required. This was observed during the audit when a resident’s condition changed, the care giver alerted the RN, who assessed the resident and contacted the GP. The GP visited the facility to conduct a medical assessment and prescribed treatment. Interview with the GP who attended to the resident confirmed their satisfaction in the timely referral for consultation and re-assessment and the appropriate nursing assessment and care. Short term care plans have not been recorded for short term problems. Family are notified of any changes in resident's condition. This was confirmed at family interviews.  There is documented evidence of additional input from health professionals, specialists or multidisciplinary sources, if this was required. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services was indicated or requested, a referral is sent to seek specialist services. Referrals are followed up by a RN or the GP, confirmed at interviews. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute/urgent referrals are attended to immediately, sending the resident in an ambulance to DHB, if the circumstances dictate. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances on an annual basis.  Chemicals are stored securely and the required personal protective equipment/clothing (PPE) is available. Staff confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons when these were required.  The caregivers demonstrated knowledge of handling waste and chemicals and were observed to keep the cleaning trolleys in sight when in use. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date May 2016). There have been no building modifications since the last audit.  The owner addresses maintenance issues as they arise and has a business plan which identifies any planned maintenance.  The areas are suitable for residents with mobility aids.  Electrical safety testing occurs annually and all electrical equipment sighted has an approved testing tag. Clinical equipment is tested and calibrated by an approved provider annually.  The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered.  There are external areas with verandas, outdoor areas with shade and access to garden areas. Residents and family members confirm that the environment is suitable to meet their needs. An internal courtyard is currently being developed. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible communal toilets/bathing facilities. There is a visitor/staff toilet. Communal toilet facilities have a system that indicates if it is engaged or vacant. Some rooms have a shared en-suite.  Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence. Residents and family members interviewed report that there are sufficient toilets and showers. |
| 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 bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. Rooms can be personalised with furnishings, photos and other personal adornments and the service encourages residents to make the room their own. Residents spoke positively about their rooms.  There is room to store mobility aids such as walking frames in the bedroom safely during the day and night, if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The service has a lounge/dining area that is also used for activities. Residents can choose to have their meals in their room. Residents are able to access areas for privacy, if required.  Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. |
| 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 | The service has procedures in place for cleaning, with staff able to describe how they complete cleaning tasks. There is a dedicated locked storage area for cleaning equipment and chemicals. Staff state that there is training on the use of products and staff are reminded to keep the trolley with them at all times. Cleaning is monitored by the facility manager. The facility was clean on the days of audit.  All laundry, including residents’ personal laundry is completed on site with a dirty and clean flow in place.  Staff and residents interviewed confirm they always have enough linen to meet day-to-day needs. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is an approved evacuation scheme dated March 2001.  Emergency management policies and procedures guide staff actions in the event of an emergency. Emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked monthly by an approved provider.  Emergency supplies and equipment include food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking.  The emergency evacuation plan and principles of evacuation are documented. All resident areas have smoke alarms and a sprinkler system. Emergency education and training for staff includes six monthly trial evacuations and there is always a staff member on duty with a current first aid qualification.  Appropriate security systems are in place with staff checking that the premises are secure at night. Staff and residents confirm they feel safe at all times. Call bells are located in all resident areas. Resident and family/whānau confirm call bells are answered within an acceptable timeframe. Call bells and sensor mats randomly checked on the day of the audit are displayed and answered in a timely manner. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area.  Family and residents state that the building is maintained at an appropriate temperature in both winter and summer. |
| 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. | PA Low | The infection control policy and procedures provide information and resources to inform staff on infection prevention and control.  The delegation of infection control matters is documented in policies, along with an infection control coordinator’s (ICC) job description. The ICC is the registered nurse. There is evidence infection related issues are communicated to staff. The infection control programme requires annual review. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has access to relevant and current information which is appropriate to the size and complexity of the service, including but not limited to: infection control manual; access to experts; and education. Infection control is an agenda item at the facilities meetings, evidenced during review of meeting minutes and interviews with staff. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control policies and procedures are relevant to the service, reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel, confirmed at staff interviews. Infection control policies and procedures identify links to other documentation in the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control education is provided to staff, as part of their orientation and as part of the on-going in-service education programme. In interviews, staff advised that care staff identify situations where infection control education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted. The ICC has conducted relevant education in infection control. |
| 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 type of surveillance undertaken is appropriate to the size and complexity of this service. The ICC is responsible for the surveillance programme. Monthly surveillance data relating to number and type of infections is recorded. The current month’s surveillance records had not been recorded, however they were completed on the second day of audit.  Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events with these retained in individual resident files. Staff report that they are made aware of any infections of individual residents by way of feedback from the facility manager or registered nurse, through verbal and written handovers and through documentation in progress notes.  An outbreak occurred in May 2015. The service accessed advice and support from the public health service and infection control specialist with an action plan documented. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the standard. The service is committed to a restraint free environment. There were no residents using restraint or enablers on audit days.  The approval process for enabler use would be activated if a resident voluntarily requested an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.  In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training was provided. |

# 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 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Low | There is an informed consent policy that outlines the process for documentation of advance directives. The GP signs to state competence of the resident. The resuscitation status is then ticked, presumably by the resident. The resident signs the form. Staff describe the process of the resident deciding on their resuscitation status, with the GP determining competence only. The form has a space to include comments by the relative or enduring power of attorney. | The advance directive form is confusing and suggests that the GP determines not only competence but also may be the person who ticks to state that they are, or are not, for resuscitation. | Review the advance directive form to clearly delineate responsibility for deciding on resuscitation status when deemed competent.  90 days |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Moderate | Most policies related to the Health and Disability Sector Standards are documented. These have been reviewed in 2015 by the manager in consultation with an external contracted registered nurse. | Some policies lack detail and some are not documented e.g. falls management and adequate documentation of wound care and management of pressure injuries and human resource policies. | Document a list of policies that require additional information or those that are required to be documented and complete documentation and implementation of these.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Incident forms are completed with evidence that these are signed off by the registered nurse. The number of incidents is collected and recorded in staff meetings with evidence of some discussion of the data. | Discussion of incidents and accidents at the staff meeting is limited, there is a lack of evidence of analysis of trends and there is limited evidence of improvement of service delivery as a result of analysis of incidents and accidents. | Analyse incidents and accidents and use the data and analysis of trends to improve service delivery.  90 days |
| Criterion 1.2.9.1  Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting. | PA Low | Progress note entries are made by staff on duty as changes occur. Entries are recorded at intervals of one to five days. The registered nurse enters notes in the individual records as well as caregivers. Records are legible and the date, name and designation of the staff member are at times documented. There is a filing cabinet available to keep resident records. | The frequency of entering in progress notes does not meet accepted good practice. Staff do not document designation for all entries in the progress notes. Registered nurses do not always date and sign other documentation at all times such as; the initial care plan and risk assessments. The key to the filing cabinet is broken and the records are not secure. | Document progress notes as per accepted good practice (daily) and as changes occur. Document staff designation with each entry, with dates entered. Keep resident records in a secure place.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Seven of ten medication files evidenced the as required (PRN) medicines (both typed by the pharmacist and hand written by the GPs) did not record the indications of use or maximum dosages. The discontinued medicines in three of ten medication charts did not evidence the medication was crossed out, or signed and/or dated by the GP.  The medicines are stored in a cupboard in the nurses’ station alcove. This area is open into the residents’ dining room and close to one of the entrances to the facility. The medication cupboard has a key lock access. On first day of the audit, the medication cupboard was observed to be left open with the medication keys in the lock. The policy and practice at the facility is for the medication keys to be held by the most senior staff member or placed on a hook out of sight. This practice was discussed with the RN and the manager and the practice of the key placement was discontinued on second day of the audit.  The medication folder evidenced the past medication charts (dating back as far as the previous year) to be located behind the current medication files.  The residents’ photos are located on a separate sheet in front of the residents’ medication charts. The photos are not dated and do not record that the residents’ resemble their current appearance. | i) As required medications (PRN) do not consistently record indication for use and maximum dosage.  ii) The discontinued medicines do not consistently evidence the medication has been crossed out, dated and /or signed by the GP.  iii) The obsolete medication charts remain with current medication charts.  iv) Medication storage area is not always secured (practice changed at audit).  v) Residents’ photos do not record the date they were taken and that the residents’ resemble their current appearance. | Provide evidence medication prescribing, storage, filing, and residents’ photos comply with legislation, protocols and guidelines.  90 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Policy on residents’ to self-administer medicines is documented. There was one resident self-administering medicine at the facility on audit day. The resident’s medication was sighted not to be secure in their room. The medicine had expired and the resident had not been assessed as competent to self-administer medications. The RN discussed the expired medication with the resident and the medicine was removed from the resident’s room. | The resident who self-administers their medicine does not do so according to policy. | Provide evidence the resident who self-administers their medicine does so according to policy.  90 days |
| Criterion 1.3.13.1  Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Moderate | The menu records the required meat option for the lunch time meal, however does not include the vegetables or salad options. Interview with the cook confirmed the meat part of the menu is followed as per menu and the vegetables/salads are prepared according to ‘in season’ availability. The menu review evidences the dietitian suggested amendments/corrective actions to the menu, however not all of these have been implemented. | There is no recorded evidence that all the corrective actions relating to the menu, that was reviewed by the dietitian, have been implemented. | Provide evidence the corrective actions required following the dietitian review of the menu are implemented.  90 days |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Moderate | The residents’ dietary profiles are located on resident’s files. Copies of the dietary profiles are provided for the kitchen staff, however not all residents’ dietary profiles were located in the kitchen folder. | Residents’ likes and dislikes, special diets and other nutritional requirements are not consistently communicated to the kitchen staff. | Provide evidence the residents’ nutritional requirements are communicated to kitchen staff.  90 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | The temperatures of fridge, freezer and cooler are conducted and documented, however they are completed every second week. Decanted foods are not dated. Kitchen cleaning schedules are not recorded and signed off when cleaning is completed. Interview with the cook confirmed cleaning is conducted by the kitchen staff and by the night staff. Some shelves in the kitchen require maintenance to ensure cleaning of the surfaces complies with infection control guidelines. | i) Fridge, freezer and chiller temperatures are not recorded weekly.  ii) Decanted food is not dated.  ii) Kitchen cleaning schedules are not recorded.  iii) Some shelves in the kitchen require maintenance. | Provide evidence: the fridge, freezer and chiller temperatures are recorded weekly; decanted food is dated; kitchen cleaning schedules are recorded and the shelves in the kitchen are maintained to acceptable standard.  180 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | There is evidence the long term care plans are resident focused and completed with the resident and/or family input. Five of five residents’ files evidenced the risk assessments (including activities assessments) were not conducted within required timeframes. Four of five initial care plans were not dated, so could not establish when they were completed (refer to criterion 1.2.9.1). Three of five residents’ files evidenced the long term care plan was not completed within the required three weeks of admission to the facility. | Service delivery timeframes are not consistently adhered to. | Provide evidence each stage of service provision is provided within the required timeframes.  90 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Residents and family interviews confirmed satisfaction with the assessment processes and the implementation of care at the facility.  InterRAI assessments are not being completed at the facility. Five of five of the initial care plans were incomplete and did not record the detail of information required for the care to be completed for the first three weeks of admission. The RN assessment was sighted in one of five files reviewed. Reassessments of risk assessments such as pain assessments were not conducted in one file reviewed. | The required assessments are not consistently completed and the initial care plans are incomplete. | Provide evidence assessments and the initial care plans are fully completed.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | The residents’ activities are provided Monday to Friday. Interview with the DT confirmed there are activities provided for the residents (such as newspaper reading, quizzes, exercises) that are not recorded on the DTs monthly planner or the weekly information white board. The residents are not provided with a paper copy of the programme and rely on the weekly activities white board information. The residents’ activities care plans record goals that are not always individualised and there are no interventions recorded to achieve these goals. | i) The activities programme does not record all activities that are provided.  ii) Residents’ activities care plans goals are not consistently individualised, do not record the required interventions and do not evidence evaluations are conducted at the same time as the care plans are evaluated. | i) Provide evidence the activities programme records all the activities that are provided and this is communicated to residents.  ii) Provide evidence the residents’ activities care plans record; individualised goals; the required interventions to achieve the activities goals and the activities care plans are evaluated at the same time as the care plans are evaluated.  90 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Review of the residents’ files that were identified with short term problems evidenced that, short term care plans were not recorded. Interview with the RN confirmed short term care plans are not completed for short term problems. Changes in residents’ needs and care provided for short term problems are communicated to the care staff via handovers and verbally, confirmed at RN and care staff interviews. GP interviews confirmed satisfaction with the care provided for residents with short term problems. | There is no recorded evidence of the use of short term care plans for residents’ short term problems. | Provide evidence short term care plans are recorded for short term problems.  90 days |
| Criterion 3.1.3  The organisation has a clearly defined and documented infection control programme that is reviewed at least annually. | PA Low | The infection control programme is part of the infection control manual/ policies. Interview with the RN/ICC and review of the documentation confirmed the infection control programme has not been reviewed annually. | The infection control programme has not been reviewed annually. | Provide evidence the infection control programme is reviewed annually.  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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End of the report.