

# Rotorua Continuing Care Trust

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## Introduction

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

The audit has been conducted by 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	Rotorua Continuing Care Trust
<b>Premises audited:</b>	Whare Aroha Home & Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 19 November 2015    End date: 20 November 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	65

# Executive summary of the audit

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## 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

Whare Aroha Home & Hospital referred to as Whare Aroha can provide care for up to 78 residents requiring care at either rest home, dementia, medical or hospital level, with 65 beds occupied on the days of audit. Of the 78 residents, 11 are under the age of 65 years. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

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

The general manager is responsible for the overall management of the facility and is supported by the operations and nurse managers. Service delivery is monitored.

Improvements required at the last certification audit to training for staff around restraint and to the medication system have been addressed. An improvement continues to be required to identification of resident needs and recording of actions to manage the needs.

This surveillance audit identified improvements required to the following: family being informed of incidents, corrective action planning, the risk management programme, implementation of the training and attendance of staff at training sessions, calibration of medical equipment and the activities 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 medium or high risk and/or unattained and of low risk.</p>
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Staff interviewed are able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and care for the residents. Information regarding the complaints process is available to residents and their family. Complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members with documentation confirming this for some incidents documented.

## 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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The service has partially implemented the documented quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and monthly reports to the board allow for the monitoring of service delivery. Benchmarking

reports include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented. Corrective action plans are documented at times and there is some evidence of resolution of issues when these are identified. There is an electronic database to record risk with risks and controls documented.

Staffing levels are adequate across the service with human resource policies implemented. This includes evidence of recruitment and employment. Staff in the dementia unit (safe care unit) are continuing to be trained in supporting and caring for residents with dementia. Further implementation of the training plan and improved attendance at training for staff is required. The previous improvement required around training around restraint has been met.

## 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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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the long term care plan is developed over the first three weeks of admission. Long term care plans are reviewed every six months, are individualised and risk assessments are completed. Residents' response to treatment is evaluated and documented. The residents and families interviewed expressed satisfaction with the activities provided by the lifestyle coordinator.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. The service implemented the Medimap system for medicines management. The general practitioner completes medical reviews of residents and medicines. Medication competencies are completed annually for all staff who administer medications. The facility utilises four weekly rotating summer and winter menus reviewed by a dietitian.

Improvements are required to behavioural, care and activity plans.

## 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.		Some standards applicable to this service partially attained and of low risk.
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There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as they arise. Residents and family interviewed describe the environment as appropriate with indoor and outdoor areas that meet their needs. Heating for the service is provided by geothermal energy with gas available in an emergency. An improvement is required to calibration of medical equipment.

## 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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The restraint minimisation programme defines the use of restraints and enablers. Policies and procedures comply with the standard for restraint minimisation and safe practice. Improvements are required to the restraint register.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff members were able to explain how to break the chain of infection. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Infections are investigated and the infection management process is appropriate. Antibiotics are prescribed according to sensitivity testing. The surveillance data is collected monthly for benchmarking.

## 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)
<b>Standards</b>	0	9	0	5	3	0	0
<b>Criteria</b>	0	34	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include timeframes for responding to a complaint. Complaint forms are available in the facility. Family and residents interviewed know where they can get a form from.</p> <p>The complaints register in place includes relevant information to track the complaint. Evidence relating to each lodged complaint is held in the complaints folder.</p> <p>Two complaints lodged in 2015 were selected for review. There is documented evidence of time periods being met for responding to these complaints with complainants happy with the outcome in each case.</p> <p>There have not been any complaints with the Health and Disability Commission (HDC) or other authorities since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>PA Moderate</p>	<p>Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Family are expected to be informed if the resident has an incident, accident, a change in health or a change in needs. An improvement is required to documentation that family have been informed.</p> <p>Files reviewed include documentation around family contact as recorded in the clinical notes. Interviews with family members confirm they are kept informed. Family confirm that they are invited to the care planning meetings for their family member.</p> <p>Interpreting services are available when required from the district health board. There are staff who can interpret in some languages including Dutch and Te reo Māori. Staff confirm that there are no residents requiring the use of interpreting services.</p> <p>An information pack is available in large print and staff interviewed advised that this could be read to residents.</p> <p>Staff training records include annual training around connecting with people and communication.</p> <p>Staff describe communicating with residents who have dementia in a way that allows choices and instigates discussions.</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>Whare Aroha Home and Hospital is owned and operated by the Rotorua Continuing Care Trust. The organisation's purpose, values, scope, direction and goals are identified in the business plan 2014-2016. The service uses the Eden Alternative Philosophy of Care.</p> <p>The business plan and risk management plan document the organisation's quality goals including goals around health and safety, infection control, staffing, risks and quality indicators. The plan sets goals and objectives and these are reviewed monthly with a report to the board.</p> <p>The general manager provides operational management and has been in this position for three years. The general manager has a postgraduate diploma in management, a diploma in business studies and a graduate diploma in community health. The general manager is supported by the operations manager, who is a registered nurse with a masters in health practice and previous experience as a director of nursing for seven years. The nurse manager provides clinical oversight and has been in the role for a year. Managers have at least eight hours of training a year, relevant to the role they are in.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>PA Moderate</p>	<p>Whare Aroha has a documented quality and risk management framework that guides practice. Benchmarking with other similar providers through an external agency has been started.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required, with all policies current. Policies are linked to the Health and</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff, with staff able to describe practice as per policy.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. Quality improvement data is analysed and some corrective action plans are documented, with some evidence of resolution of issues.</p> <p>There are monthly meetings with minutes documented that include the following: board; health and safety; falls prevention; restraint; quality and team; staff; clinical. Meetings are held quarterly with resident and family. All staff interviewed report that they are kept informed of quality improvements.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are also in place for the service, which includes a documented hazard management programme and a hazard register for each part of the service. The risks including hazards are documented electronically with controls put in place.</p> <p>There is an annual satisfaction survey for residents and family. The survey completed in 2015 indicates that residents and family are satisfied or very satisfied with care and support provided.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>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.</p>	<p>FA</p>	<p>The nurse manager is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff records reviewed demonstrate that staff receive education at orientation on the incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events. Information gathered is regularly shared at monthly meetings with benchmarking of incidents just beginning.</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</p>	<p>PA Low</p>	<p>Human resource policy and processes are in place. All registered nurses hold current annual practising certificates. Current visiting practitioners' practising certificates reviewed are current and include the general practitioners, pharmacists, podiatrist and physiotherapist. Staff files include employment documentation such as job descriptions, contracts and appointment documentation on file.</p> <p>Criminal vetting is completed and an annual appraisal process is in place with all applicable staff</p>

<p>of legislation.</p>		<p>having a current performance appraisal.</p> <p>An orientation programme is available for staff and staff files indicate that this has been completed.</p> <p>A training plan for 2015 is documented, with some training provided as per the plan. All staff have attended restraint and manual handling training and the improvement required at the previous audit has been met. There is low attendance at other training. Registered nurses have at least eight hours of clinical training a year. Staff interviewed are knowledgeable about their roles.</p> <p>Caregivers working in the safe care unit have either completed their dementia training or are completing this. There are other staff in the service who have completed dementia training who can provide support in the unit if required.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required, due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy.</p> <p>There is a roster for the safe care unit and rest home services, which are located on the ground floor, and the hospital service located on the upper floor. There is always a registered nurse on duty, 24 hours a day, with the nurse manager providing oversight of care in the safe care unit and rest home. The caregiver on duty overnight carries a portable phone and can access another staff member or registered nurse when required. Staff confirmed that staff come to the unit immediately if rung. Registered nurses are rostered for 12-hour shifts.</p>
<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>	<p>FA</p>	<p>Medicine management policies and procedures are in place, implemented and include processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication areas are free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner. Medicine charts listed all medications the resident was taking, including name, dose, frequency and route to be given. The service uses the Medimap system for medicines management.</p> <p>Allergies are recorded. All residents had photo identification. Three monthly GP reviews were all completed within the three monthly timeframe.</p> <p>Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily. Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Unwanted or expired medications are collected by the pharmacy. Medication administration was observed during lunch time in the hospital. The staff member checked</p>

		<p>the identification of the residents, completed cross checks of the medicines against the script, administered the medicines and then signed off after the resident took the medicines.</p> <p>Staff were authorised to administer medications. This requires completion of medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies. Self-administration of medicine policies and procedures are in place. There were no residents who self-administered their own medication. Medicines management training occurs for staff.</p> <p>The previous requirement for improvement relating to a GP using brackets to sign off medicines on the medicines administration chart is met.</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>The food service policies and procedures are appropriate to the service setting with seasonal menus reviewed by a dietitian. Residents' dietary profiles are developed on admission and reviewed six monthly, or when resident's condition changes. There are current residents' dietary profiles in residents' files and copies in the kitchen. The kitchen staff are informed if resident's dietary requirements change.</p> <p>Interviews with kitchen staff confirm their awareness of the residents' dietary requirements. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. Residents who require special eating aids are provided for to promote independence.</p> <p>The residents' files demonstrated monthly monitoring of individual resident's weight. Supplements are provided to residents with identified weight loss. In interviews, residents stated they are satisfied with the food service. Residents reported their individual preferences are met and adequate food and fluids are provided. The residents' meeting minutes' evidence feedback about the food service is positive. The service provides additional food over 24 hour period for residents with dementia.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>The residents' files are organised to facilitate easy use of the folder. The long term care plans identify goals. Goals are realistic, achievable and clearly documented. The service records intervention for the achievement of the goals.</p> <p>The previous requirement for improvement relating to the management of behaviour over 24 hours remains open. However, the service started including a description of how the behaviour of the residents in the safe care unit is best managed over a 24 hour period. The process of how the service</p>

		got to the conclusion that a resident presenting with certain behaviours and the actions taken to effectively manage these behaviours is not currently documented.
<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>	PA Moderate	<p>Residents' receive adequate services, meeting most of their assessed needs and desired outcomes. Interventions are documented for each goal in the care plans. Interview with the GP confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long term care plans such as: the speech language therapist; the occupational therapist; dietitian; needs assessment service coordinators (NASC) and the physiotherapist.</p> <p>Multidisciplinary meetings are conducted to discuss and review long term care plans. The initial assessment includes using various risk assessment tools to establish the needs of the new residents, however not all risks as identified during the assessments were reflected in the long term care plans. Records do not show evidence of family and/or the residents contributing to the long term care plans.</p> <p>There is a requirement for improvement relating to all risk assessments having to be reflected in the long term care plan, and all residents' care plans to be signed, by the resident or their family, to confirm their contribution to the long term care plan.</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>	PA Low	<p>The activities programmes confirm that independence is encouraged and choices are offered to residents. The lifestyle coordinators (LC) work with the input of an occupational therapist in the planning and implementation of the activities programmes. The service had 11 residents under the age of 65 at the time of the audit.</p> <p>Activities include: physical; mental; spiritual and social aspects of life to improve and maintain residents' wellbeing. During the onsite visit, activities included residents going for an outing, music and one-on-one activities.</p> <p>There is a requirement for improvement relating to not all residents having completed activity assessments, activity plans, review of activity plans, and residents who are under 65 do not have their additional activities identified on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed showed long term care plans had six monthly reviews completed. Clinical reviews are documented in the multidisciplinary review (MDR) records, which include input from: the GP; RNs and care givers. Progress notes are completed at every shift. Progress notes reflect daily response to interventions and treatments. Residents are assisted in working towards goals. Short term care plans are developed for acute problems, for example, infections, wounds, falls and other short</p>

		term conditions.
<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>	PA Low	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date December 2015). There have been no building modifications since the last audit.</p> <p>A planned maintenance schedule is implemented and the maintenance staff and documentation confirmed implementation of this. A maintenance book is kept in each area of the service and staff record any issues. The maintenance staff check the books daily, with documentation completed to confirm that the issues have been addressed.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids.</p> <p>There is enough equipment to support care needs, as confirmed by staff interviewed. A test and tag programme is in place, however there are improvements required to calibration of medical equipment. Water is heated through a boiler that uses geothermal energy. A back up gas heating system is available for emergencies to heat the boiler. The geothermal heating is checked monthly and the gas is checked at least annually. Checks are completed by an external company (refer 1.2.3.9).</p> <p>There are safe external areas for residents and family to meet/use and these include paths, seating and shade.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organisation. Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators on the intranet.</p> <p>Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on monthly at staff, quality, and infection control and health and safety meetings. Interviews confirmed information relating to infections is made available for clinical staff during hand over and at staff meetings.</p> <p>The responsibility for the surveillance programme is that of the nurse manager (NM). Information gathered was clearly documented in the infection log and maintained by the infection control coordinator (ICC). The ICC collects infection control data and collates the surveillance data for benchmarking. The infection control surveillance register included monthly infection logs and antibiotics use.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>Restraints used in the facility include lap belts and bedrails. There were seven residents using restraints and four residents using enablers on the days of the on-site audit. The files reviewed for restraint and enabler use showed enabler use was voluntary and the least restrictive option for the resident. Residents who used restraints had risk management plans in place. The restraints were documented in their person centred care plans. There were no restraint related injuries reported.</p> <p>Reasons for restraint use were considered and documented in the restraint assessments. The restraint coordinator is the nurse manager (NM). The service has a documented system in place for restraint use, including a restraint register for 2014.</p> <p>There is a requirement for improvement relating to the restraint register not being current.</p>
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## 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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	<p>PA</p> <p>Moderate</p>	<p>Staff record incident forms electronically. Of the 30 incident forms reviewed, 10 included documentation that family had been informed.</p>	<p>Twenty of the thirty incident forms reviewed did not include evidence that family have been informed on the incident form. Two of the 20 reviewed were files reviewed by the clinical auditor and both had a progress note documented that stated that family had not been informed despite these being significant events.</p>	<p>Document evidence that family have been informed following an incident.</p> <p>30 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Moderate</p>	<p>A process to record corrective action plans is able to be used and there is some evidence of documentation of corrective action plans, with some evidence of resolution of issues documented.</p>	<p>At times, corrective action plans and evidence of resolution is not documented. Examples sighted included those from internal audits and satisfaction surveys.</p>	<p>Document corrective action plans and evidence of resolution of issues as these are identified.</p> <p>180 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	<p>PA Moderate</p>	<p>There is an electronic system of recording risks, including hazards. Risks and hazards are entered, with controls put in place to eliminate, isolate or minimise. A risk rating is generated before controls are put in place and another generated after the controls have been entered. A matrix of likelihood of the risk occurring, and the level of seriousness should the risk occur, leads to the risk rating. Controls reviewed are documented appropriately for the risk identified.</p>	<p>i) The risk rating generated does not always drop despite controls being put in place. Three risks identified, for example, where risks were identified as extremely high and moderate did not change despite controls being entered. The system informed the reader to address the risks.</p>	<p>i) Ensure that risks are re-assessed when they remain as moderate or higher on the risk rating or if they do not drop after controls have been put in place.</p> <p>30 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>Training records are kept electronically and on staff files. A training plan is documented that includes topics related to the Health and Disability Sector Standards and clinical care.</p>	<p>i) The training plan is not well implemented as per the schedule.</p> <p>ii) Attendance at staff training sessions is low with some training cancelled because of a lack of attendance and</p>	<p>i) Implement the training plan.</p> <p>ii) Ensure that staff attend training relevant to their role.</p>

			most attracting up to 12 staff members	180 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	<p>Short term care plans are developed as and when required for acute problems. The long term care plans assessed during the on-site audit were reviewed six monthly. The service implements a plan for the management of behaviour relating to loneliness, helplessness or boredom over 24 hours. The service includes a description of what these behaviours are but does not include a record of the process of data collecting to identify the behaviours of loneliness, helplessness or boredom and/or a record of the actions which effectively manage these behaviours for each resident in the safe care unit.</p>	<p>i) The process of collecting the information in order to identify the behaviours of loneliness, helplessness or boredom is not currently being recorded</p> <p>ii) The actions taken to effectively manage these behaviours are not currently documented for each resident in the safe care unit.</p>	<p>i) Record evidence of the process of data collecting to identify the behaviours of loneliness, helplessness or boredom.</p> <p>ii) Record evidence of the actions which effectively manage these behaviours for each resident in the safe care unit.</p> <p>180 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>Review of 11 resident files included a comparison of risk assessments to the long term care plans to ascertain how current the goals and interventions, as identified in the long term care plans, are. There was no recorded evidence of residents/family contributing to the long term care plans.</p>	<p>i) The long term care plans assessed during the on-site audit did not show evidence of the residents, or family, having made input into/or evidence of their contribution to the plans.</p> <p>ii) Not all results from risk assessments are reflected in the long term care plans.</p>	<p>i) Long term care plans to evidence residents/family having made input into, or evidence of, their contribution to the long term care plans.</p> <p>ii) All results from risk assessments to be reflected in the long term care plans, including</p>

				pain and restraint.  90 days
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>The service is in the process of changing their activities documentation and records and the new records have not been implemented for all residents. Residents did not all have completed activity assessments, plans, reviews and residents under 65 did not have additional activities recorded.</p>	<p>i) Not all residents had completed activity assessments</p> <p>ii) Not all residents had activity plans identifying their specific abilities, interests and wants.</p> <p>iii) No evidence of activities care plans being reviewed at six monthly intervals</p> <p>iv) Residents under 65 do not have additional social activities recorded</p>	<p>i) All residents to have completed activity assessments</p> <p>ii) All residents to have activity plans identifying their specific abilities, interests and wants.</p> <p>iii) All residents to have six monthly reviews completed of their activity plans/assessments</p> <p>iv) All residents under 65 to have additional social activities recorded</p> <p>180 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>An external company calibrates the scales annually.</p>	<p>All medical equipment is not calibrated annually.</p>	<p>Calibrate medical equipment annually.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p>	<p>PA Low</p>	<p>The service uses bedrails and lap belts as restraints or enablers. There were seven</p>	<p>The restraint register</p>	<p>The restraint register to reflect</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>residents using restraints and four residents using enablers on the days of the on-site audit. Reasons for restraint use were considered and documented, however the restraint register was that of 2014.</p>	<p>was not current.</p>	<p>all restraint and enabler use.  90 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.