

Whangaroa Health Services Trust

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

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

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

The specifics of this audit included:

Legal entity:	Whangaroa Health Services Trust
Premises audited:	Whangaroa Health Services
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 March 2016 End date: 10 March 2016
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	18

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	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
Red	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

Whangaroa Health Services Trust operates a community owned primary health care service and an aged residential care service. The Kauri Lodge aged care service has 22 beds and provides rest home and hospital level care. On the day of the audit there were 18 residents. The trust board employs a chief executive officer, a cultural and compliance manager, human resources manager and clinical services manager to implement the strategic plan and oversee the day to day operations of all services.

The residents and relatives spoke positively about the care and supports provided at Whangaroa Health Services Kauri Lodge.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations and interviews with residents, relatives, nurse practitioner, management and staff.

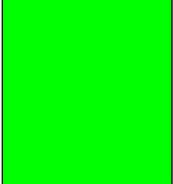
Environmental improvements include new decking around the building and upgrading of gardens. The service has added another room designed for palliative care and is spacious enough to accommodate whānau.

The service has addressed seven of twelve previous audit findings relating to corrective actions, the admission agreement, progress notes entries, care planning, evaluations, first aid training and infection control surveillance.

Further improvements are required in relation to conducting quality activities, staff education needs, interRAI assessment timeframes, care interventions and activity plan reviews.

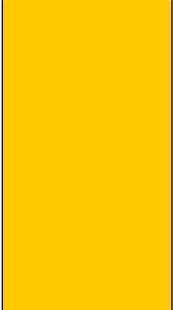
This audit identified shortfalls around staff recruitment, orientation and medication storage.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service ensures effective communication with all stakeholders including residents and families. Management have an open door policy. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Whangaroa Health Services has a quality and risk management system in the process of being re-established. This includes collection of accident and incident data, complaints, restraint and internal audits. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and appropriately managed. There is an orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service

education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses assess and review residents' needs, outcomes and goals with the resident and/or family. Initial assessments, risk assessments and long-term care plans have been developed within the required timeframes. Resident files included medical notes and notes of other visiting allied health professionals.

A diversional therapist provides an interesting and varied activities programme for the residents, which includes outings and community involvement. Entertainers, community members and volunteers are involved in the activity programme.

Medication management policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies. Medication charts had been reviewed by the general practitioner/nurse practitioner at least three monthly.

All meals are prepared on-site. Individual, special dietary and cultural needs are catered for. Alternative options are available for resident's dislikes. The menu has been reviewed by a dietitian.

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.

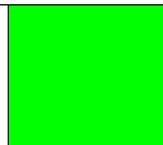


Standards applicable to this service fully attained.

The building holds a current warrant of fitness.

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.

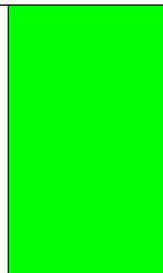


Standards applicable to this service fully attained.

There is a restraint policy that includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service has a restraint “champion” and approval committee. On the day of the audit, there was one resident on restraints (bedrail) and two residents with enablers (bedrails).

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 and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control champion (registered nurse) is responsible for collating infection events and providing a monthly report to management and staff. Infection control policies and guidelines include definitions for surveillance. The infection control champion uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	13	0	4	2	0	0
Criteria	0	34	0	7	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the chief executive officer who is the privacy officer. There have been no complaints that relate to the aged care service at Kauri Lodge. Residents and family members interviewed advised that they are aware of the complaints procedure. Management have an open door policy.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	Five residents (two hospital and three rest home) and two family members (of hospital level residents) interviewed stated they are informed of changes in health status and incidents/accidents. This was confirmed on incident forms sighted. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. The chief executive officer (CEO) and clinical services manager have an open door policy. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available.

communication.		
<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>	FA	<p>Whangaroa Health Services is governed by a trust board, comprised of representatives from the local community. The service provides care in Kauri Lodge for up to 22 residents at hospital and rest home level care. On the day of the audit, there were 18 residents in total with 11 residents at rest home level (including one respite resident) and 7 residents at hospital level (including one younger person at hospital level under ACC funding). All other rest home and hospital residents were under the ARC contract.</p> <p>The service is managed by a CEO who is a trained social worker with a law degree and has been in the role since February 2015. The CEO is supported by a finance and human resources manager, a cultural and compliance manager and a clinical services manager (registered nurse). The clinical services manager (CSM) has been in the position since October 2015 and has undergone a comprehensive orientation programme. The CEO provides a monthly service management report to the board.</p> <p>The goals in the business plan for 2014-2015 have been reviewed and evaluated (sighted in the annual report dated 30 June 2015). The draft business plan and goals for 2016-2017 is to be confirmed at the March board meeting.</p> <p>The CSM has completed professional development activities related to managing a rest home and hospital.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>The quality and continuous improvement plan 2015-2016 describes Whangaroa Health Services quality improvement processes for Kauri Lodge. The quality and continuous improvement plan describes objectives, management controls, key tasks, assigned responsibility and outcomes. A continuous quality improvement team (CQI) was implemented in March 2015. The team is made up of “champions” within the following key clinical areas: falls prevention, infection control, continence, pressure injuries, medicines and wound care. The CQI team meet monthly and is committed to providing high quality care and services to each resident and their family/whānau.</p> <p>Not all internal audits were completed as scheduled for 2015. Corrective actions have been developed, implemented and signed off for completed audits. The previous finding around corrective action plans have been addressed. Staff and management meetings are held regularly and evidence discussion around quality data including health and safety data and trends. The previous finding has been addressed around meetings and discussion around health and safety data and trends. Staff interviewed are aware of infection control and health and safety data, trends and quality initiatives.</p> <p>The service participates in a benchmarking data group with four other facilities in the Far North. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management.</p> <p>Resident/relative meetings have been held bi-monthly. Residents’ surveys are scheduled to occur however no</p>

		survey was completed for 2015. There was no resident/family satisfaction survey completed for 2015.
<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>	FA	<p>A sample of ten resident related incident reports for February 2016 was reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service has recently recommenced benchmarking incident data with other facilities.</p> <p>Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service reported a missing medication incident to HealthCERT and the DHB. The incident was fully investigated by an external auditor appointed by the DHB. The police were notified and no further investigation was required.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>The recruitment and staff selection process requires that relevant checks have been completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files (one clinical nurse manager, one RN, one cook, one diversional therapist and one caregiver) were reviewed. Not all files reviewed evidenced contracts or job descriptions, or completed orientation documentation. Staff turnover was reported by the CEO as being low.</p> <p>The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual performance appraisals were up to date in the staff files sampled. The previous finding has been addressed around performance appraisal requirements. There is an in-service training/education calendar for 2015 however, not all training sessions were completed as scheduled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</p>	FA	<p>Whangaroa Health Services has a two weekly roster in place which provides sufficient staff coverage for the provision of care and service to residents. There is at least one registered nurse on duty at all times. The CEO and clinical services manager work full time from Monday to Friday and are on call 24/7 for any non-clinical and clinical related concerns. Caregivers, residents and family interviewed advised that sufficient staff is rostered on for each duty.</p>

and safe service from suitably qualified/skilled and/or experienced service providers.		
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	The service uses an admission agreement that has been developed by a recognised aged care industry association. The admission agreement aligns with the ARC contract. The previous finding has now been addressed.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>Medication policies and practice align with accepted guidelines. The RNs are responsible for the administration of medications. Registered nurses have completed comprehensive annual medication questionnaires, practical skills checklist and attend syringe driver refreshers. The RNs have received annual education. Medications are checked on arrival by the registered nurse evidenced by signatures on the blister pack and administration signing sheet. Any pharmacy errors are recorded and fed back to the supplying pharmacy. There was one self-medicating resident with completed self-medication competencies in place that have been reviewed three monthly. Standing orders form in use meets the requirements for standing orders. All eye drops sighted had been dated on opening. Medications viewed were all within the expiry dates. The medication fridge temperature is monitored daily. There was no evidence of corrective actions for temperatures outside of the acceptable range.</p> <p>Ten medication charts and administration signing sheets were viewed. Medication charts are pharmacy generated. All charts had photo identification and allergy status noted. Prescribing met legislative requirements for regular and as required medications. Signing sheets reviewed corresponded with the medication charts. As required medications were signed, dated and timed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	FA	<p>All food is prepared and cooked on-site. A qualified chef (interviewed) is employed Monday to Friday and is supported by a weekend cook. All staff have completed food safety training. Caregivers heat and serve the pre-prepared evening meals. A four weekly seasonal menu is in place and has been reviewed by a dietitian.</p> <p>The meals are prepared in the main kitchen and served from a bain marie to the rest home and hospital dining</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>rooms. The chef is notified of resident dietary requirements, dietary changes and resident dislikes. Special diets including soft/moulied and dislikes are accommodated. Registered nurses have access to the kitchen after hours if required.</p> <p>Fridge and freezer temperatures are recorded daily. End cooked meat temperatures are taken and recorded on at least five days per week. All foods were date labelled and stored correctly. A cleaning schedule is maintained. The chef was observed to be wearing appropriate personal protective clothing.</p> <p>Residents have the opportunity to provide feedback on the meals through direct contact with the chef and resident meetings.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>Long-term care plans in resident files reviewed reflected the residents' current health status and outcomes identified through the risk assessment process. Short-term care plans are used for short term/specific problems as viewed for pain, shortness of breath and infections. The long-term care plans had been updated with any ongoing problems that had not resolved. There was documented evidence of resident/whānau participation in the development and review of care plans. The previous finding around care plan documentation and resident/whānau involvement in care planning has been addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP/NP visit or nurse specialist referral. There is evidence of monthly medical reviews for hospital residents and three monthly for rest home residents or earlier for health status changes. Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Family confirmed they were kept informed of any changes to resident's health status. Progress notes record communication with family.</p> <p>Staff report there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. There were five skin tears, one chronic wound and one grade I pressure injury (facility acquired) being treated on the day of audit. Not all dressings had been changed at the required frequency.</p> <p>Monitoring forms and charts available for use include (but not limited to) observations, weight, blood sugar levels, neurological observations, restraint, pain monitoring and challenging behaviour charts. There were no documented interventions for one rest home resident with weight loss. Monthly weighs had not been completed as per policy.</p> <p>A shortfall was identified around documented interventions for residents at risk of pressure injury and falls.</p> <p>The previous finding remains around interventions.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>The service employs a diversional therapist (DT) who registered in 2015. The DT is employed for three days a week. She attends the monthly DT regional meetings and on-site education. The DT has a current first aid certificate.</p> <p>The rest home and hospital activity programme is integrated with a variety of activities that are meaningful to the residents such as crafts, gardening, walks, board games and happy hours. Caregivers initiate activities as per the programme in the weekends. There are activity resources readily available for staff to use. Volunteers participate in the delivery of the programme such as walks, crafts and one on one time with residents.</p> <p>Special events are celebrated. Community members are involved with entertainment, library, church services and Tai Chi classes. Residents are encouraged to maintain links with community groups. Facility vehicles are available for outings.</p> <p>Residents have the opportunity to feed back on the activity programme through monthly meetings. Activity plans were sighted in the resident files reviewed; however, these have not been reviewed at the same time as care plans. This previous finding around activity plan reviews remains.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial nursing assessment and care plans have been evaluated by the RN within the required timeframes. InterRAI assessments have been completed for residents with changes to health status (link 1.3.3.3.). Long-term care plans reviewed had been evaluated at least six monthly by the RN and any other allied health professionals involved in the resident's care. A written evaluation indicates if the resident goal has been met or unmet. Short-term care plans in use have been reviewed regularly by the RN and documents if the problem has been resolved or added to the long-term care plan if the problem is ongoing. The previous finding around the review of short-term care plans has been addressed.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The service displays a current building warrant of fitness which expires on 31 August 2016.</p> <p>The community has been involved in environmental improvements including the painting of the exterior of the facility. New decking has been built around the building with ramp access from several locations. There is new seating and a shade sail. Gardens have been upgraded and include raised gardens.</p> <p>There has been a reconfiguration of the service to include an additional palliative/carer support room that is spacious enough to accommodate family/whānau. There is private access to the outdoor deck area from the room.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Staff have been provided with training in emergency situations including fire safety with six monthly fire drills. All registered nurses and the DT has completed first aid certificates. The previous finding around a first aider on duty at all times has been addressed.</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>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control “champion” is an RN. The infection control champion collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are in place appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and collated monthly. Data is analysed for trends which is discussed and reported to the monthly continuous quality improvement/RN meetings. Monthly and annual comparisons are available for staff information. The previous finding around infection control surveillance has been addressed.</p> <p>There is close liaison with the GP/NP and Whangaroa Health Services that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. The service participates in a regional benchmarking programme. The regional infection control group meet three monthly.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. The service has a restraint “champion” and approval committee. There was one resident on restraint (bedrail). There were two residents with enablers (bedrails). Enablers are voluntary and the least restrictive option. Staff completed restraint and challenging behaviour training in August 2015.</p>

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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is a quality and continuous improvement programme in place. Annual resident surveys are scheduled to provide residents/relatives the opportunity to feedback on service delivery and identify opportunities for improvement. The annual resident/relative survey is included in the quality improvement plan. Quality data is gathered from incidents and accidents. The CEO and CSM have ensured the plan for conducting internal audits has been completed as scheduled since January 2016.	i) The annual resident/relative survey for 2015 has not been completed; and ii) internal audits for 2015 have not been completed as scheduled.	i) Ensure the resident/relative satisfaction survey is completed annually, collated and results communicated to participants; and ii) ensure internal audits are completed as scheduled. 90 days
Criterion 1.2.7.3 The appointment of appropriate service	PA Low	Three of five files contained the required employment documentation including employment contracts and	Two staff files reviewed did not have employment contracts and signed job descriptions.	Ensure all staff has a copy of the employment agreement and a signed

providers to safely meet the needs of consumers.		signed job descriptions.		job description on their personnel file. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	Three staff files reviewed evidenced completed orientation programmes. Staff interviewed state newly appointed staff received adequate orientation time related to their role.	Two staff files reviewed did not evidence a completed orientation plan.	Ensure that all staff files complete an orientation plan. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	The in-service education programme for 2016 is being implemented. Education was not provided for all topics as planned. Topics not provided as scheduled for 2015 included abuse and neglect, cultural awareness, privacy and dignity, sexuality and intimacy, spirituality and counselling and falls prevention.	The education calendar for 2015 has not been fully completed as scheduled.	Ensure that the education and training needs for staff are provided as per the schedule. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage,	PA Low	The medication fridge is stored in a locked medication room. Medications within the fridge were all within the expiry dates. The medication temperature is checked daily. Medication fridge temperature recordings reviewed have been above 8 degrees Celsius on several readings over the past month.	There is no evidence of corrective actions taken to ensure the temperatures are maintained between 2 and 8 degrees Celsius.	Ensure corrective actions are taken for medication fridge temperatures outside of the acceptable range. 60 days

disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.				
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Low	All resident files including the respite care resident had an initial assessment on admission and care plan developed within the required timeframes. Three of four permanent resident files did not evidence interRAI assessments completed within the required timeframes.	InterRAI assessments had not been completed within 21 days for two hospital level residents. There was no interRAI assessment tool utilised with the care plan review (February 2016) for one rest home resident.	<p>Ensure interRAI assessments are completed within 21 days of admission and with care plan reviews as of 1 January 2016.</p> <p>60 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>Acute wound assessments and a wound management plan had been completed for the chronic wound and pressure injury. Skin tear management plans had been completed for the five skin tears. Wound evaluations and change of dressings had not been completed for wounds as required. The CSM and RN could describe the referral process to access a wound nurse specialist if required.</p> <p>Resident weights are required to be completed monthly or more frequently for residents with weight loss. One rest home resident with weight loss had not been weighed monthly.</p> <p>The care plans of two residents</p>	i) Wound evaluations and change of dressings had not been completed at the documented frequency for four skin tears, one chronic wound and one stage I pressure injury; ii) there were no documented interventions for a rest home resident with weight loss. The resident had not been weighed monthly as per protocol; iii) There were no documented interventions for the prevention of pressure injury for two hospital residents at risk of pressure injury; and iv) There were no documented falls prevention strategies for one rest home resident assessed as a moderate risk of falls.	i) Ensure wound evaluations and change of dressings are completed at the documented frequency; ii) ensure all residents are weighed monthly and interventions for weight loss are documented on a short-term care plan; and iii) and iv) ensure documented interventions reflect the residents assessed risk for pressure injury and falls.

		(hospital) identified as high risk of pressure injury, did not have adequate pressure injury interventions documented in the care plan. One rest home resident assessed as a moderate risk of falls did not have adequate falls prevention strategies documented in the care plan.		30 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 Low	Residents have a history profile completed on admission as sighted in the resident files reviewed. Activity plans are in place and the DT records activity progress notes. Activity plans are reviewed six monthly.	Activity plans had not been reviewed at the same times as the care plans.	Ensure activity plans are reviewed at the same time at the care plans. 60 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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.