Windsor House Board of Governors

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: Windsor House Board of Governors

Premises audited: Windsorcare

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

Dates of audit: Start date: 31 October 2016 End date: 31 October 2016

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: 76

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Windsorcare Retirement Village cares for up to 81 residents requiring rest home, dementia or hospital level care. On the day of the audit there were 76 residents.

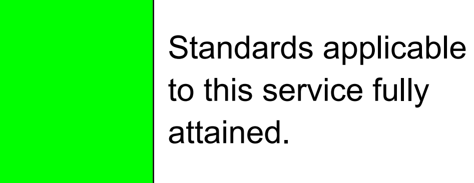
The service is being overseen by a general manager who has been in the role since June 2015 and is supported by a recently appointed clinical manager, a support services manager and an administration manager. Residents and relatives interviewed spoke positively about the service provided.

This surveillance audit was conducted against a subset of the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The previous certification audit did not identify any areas requiring improvement.

This audit has identified areas for improvement around corrective action plans, staff training and performance appraisals, review of risk assessments, care interventions, care plan evaluations, medication management, infection control surveillance and outbreak management.

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.

The service operates in a manner that promotes open disclosure. Care plans accommodate the choices of residents and/or their family/whānau. Policies are implemented to support residents’ rights and complaints management. 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.

Windsorcare has a current strategic plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality programme includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Aspects of quality information are reported to a variety of staff and management meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at regular resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings.

Windsorcare has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing and caregivers, residents and family members report staffing levels are sufficient to meet resident needs.

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.

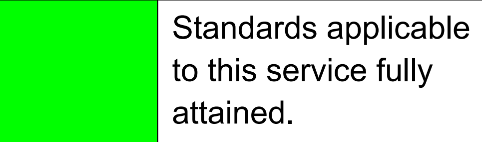
Assessments, care plans and reviews are completed by a registered nurse. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

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.

Windsorcare has a current building 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. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently eight hospital level residents requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

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.

Standardised definitions are used for the identification and classification of infection events. Infection incidents are recorded.

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	9	0	3	4	0	0
Criteria	0	32	0	3	4	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 service has a complaints policy that describes the management of complaints process. There is a complaint form available. Information about complaints is provided on admission. Interview with residents and relatives demonstrated an understanding of the complaints process. All staff interviewed (four caregivers – one from the dementia unit, two from the rest home and one from the hospital, three registered nurses – one from each area, one diversional therapist and one activities coordinator) were able to describe the process around reporting complaints. There is a complaint register. There have been seven complaints in 2016 to date. Six of these (randomly sampled) were reviewed in detail. Verbal and written complaints are documented. All complaints have noted investigation, timelines, corrective actions when required and resolutions. Results are fed back to complainants.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to	FA	Residents (five hospital level and four rest home level) and families (one rest home level and one dementia level) interviewed, stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around

effective communication.		open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were viewed. The form includes a section to record family notification. Forms sampled indicated family were informed or if family did not wish to be informed. Relatives interviewed reported they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Windsorcare Retirement Village service provides dementia (20 beds), rest home (20 beds) and hospital level care (41 beds) for up to 81 residents. On the day of the audit there were 76 residents including 20 dementia residents, 20 rest home residents (including one resident funded by the Earthquake Commission) and 36 hospital level residents. Two of three dual-purpose rooms were in use – one rest home resident in the rest home unit and one hospital resident in the hospital unit. All permanent residents were on the ARC contract. The general manager has been in aged care management since 2014 and has been in the role since June 2015. He is supported by a clinical manager who had been in the role for seven weeks, and has had aged care residential manager and clinical manager experience. Other management support includes a support services manager and an administration manager. Windsorcare has a strategic plan and a quality and risk management programme in place for the current year. The organisation has a philosophy of care which includes a mission statement. The general manager has completed in excess of eight hours of professional development in the past 12 months.
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 Low	There is a quality plan that includes quality goals and risk management plans for Windsorcare. Interviews with staff confirmed that quality data is discussed at monthly quality and risk management meetings and the minutes are made available to all staff. Quality data is also posted in the staff room. The quality person (a registered nurse) is responsible for providing oversight of the quality programme. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies have been reviewed regularly and updated to include InterRAI requirements. Resident/relative meetings are held. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities did not always have a corrective action plan developed. The service has

		a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place, including accident and hazard management. The health and safety programme is overseen by the support services manager. The health and safety programme has been revised following recent legislative changes. A death/Tangihanga policy and procedure outlines the immediate action to be taken upon a consumer's death, to ensure that all necessary certifications and documentation are completed in a timely manner. Falls prevention strategies are implemented for individual residents although staff have not received recent training to support falls prevention (link 1.2.7.5). Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical manager and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality meetings, including actions to minimise recurrence. Ten incident forms sampled (three from the dementia unit, three from the rest home and four from the hospital) documented clinical follow-up of residents is conducted by a registered nurse. All incidents are reviewed at the health and safety meeting and a sample of incident forms are audited each month around actions taken to review recurrence. Discussions with the general manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications, with five appropriate section 31 notifications having been made around pressure injuries in 2016.
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.	PA Moderate	There are human resource management policies in place, which include that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (one cook, one diversional therapist, three caregivers and two registered nurses). Files reviewed evidenced that reference checks had been completed before employment was offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2015 has been completed and the 2016 programme is being implemented. However, staff attendance is low and not all required sessions have been provided. There are 11 caregivers who work routinely in the dementia unit and all have completed the dementia standards.

		The clinical manager and registered nurses are able to attend external training including sessions provided by the local DHB. Annual staff appraisals were not evident in all staff files reviewed.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Policies include staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. There are either two registered nurses or a registered nurse and an enrolled nurse rostered in the hospital for morning and afternoon shift and one registered nurse overnight. A registered nurse works three days per week, and an enrolled nurse four days per week, in the dementia unit. A registered nurse works five days per week in the rest home. Additionally, the clinical manager works five days per week. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.
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	Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication was not consistently documented as being given as prescribed, for the sample of 12 medication charts reviewed (four rest home, four hospital and four dementia). The enrolled nurse (EN) and senior caregivers administer medicines to rest home residents, and registered nurses administer medications to hospital residents. In the dementia unit, the EN, RN and medication competent caregivers administer medications. Staff who administer medication have been assessed as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The RNs reconcile the delivery and this is documented. Medication charts are written by medical practitioners and there was evidence of three monthly reviews by the GP. 'As required' medications were not consistently charted in line with guidelines and documentation of allergy status was not consistently documented. There were no residents self-administering medicines. Standing orders were not in use.
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	FA	The food service at Windsor care is provided by trained staff in a well-appointed kitchen. Food service manuals are in place to guide staff. Each unit has its own dining area. Food is transported in hot boxes to the rest home, hospital and dementia units. A resident dietary profile is developed for each resident on admission and is provided to the kitchen staff and likes and dislikes are catered to.

service delivery.		The kitchen is able to meet the needs of residents who require special diets and the cooks work closely with the registered nurses. Kitchen staff have completed food safety training. The cooks follow a rotating menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are routinely monitored and recorded. There is special equipment available for residents if required. Extra snacks, fruit, desserts and sandwiches were available in the dementia unit 24 hours a day. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Caregivers follow the care plans and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral. Staff have access to sufficient medical supplies including dressings. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Monitoring forms are in place for restraint use, behaviour management, and fluid balance charts, turning charts and pain management. There were twenty four wounds (twenty one in the hospital including one pressure injury assessed as stage 2 and one stage 3 pressure injury, one in the rest home [a chronic wound] and two skin tears in the dementia unit). Wound documentation was available and includes assessments, management plans, progress and evaluations, however not all wound documentation was fully completed. Not all care plans contained appropriate interventions to meet the desired goals and outcomes.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There are three activities staff who facilitate the activities programme for all residents. One staff member is a diversional therapist. Each resident has an individual activities assessment on admission and from this information, an individual activities plan had been developed by the activities staff for the resident files sampled (link 1.3.6.1). An activities programme operates concurrently in the dementia unit, the rest home and the hospital staff. Caregivers in the dementia unit provide activities when the activities staff are not available. The activities programme reflects the residents' cognitive and physical abilities. Activities are provided for each morning and afternoon from Monday to Saturday.

		Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Residents and families interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status. Reviews document progress toward goals. There is at least a three monthly review by the GP. Changes in health status are documented and followed up. Where progress is different from expected, short-term care plans were not consistently implemented or the long-term care plan updated to reflect the change in residents' needs.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service displays a current building warrant of fitness.
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.	PA Low	Infection surveillance is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and discussed in meetings. Outcomes and actions are discussed at quality meetings and minutes posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical manager. An outbreak in June 2016 was appropriately managed, but an outbreak log was not maintained.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were eight residents with restraint and no residents with an enabler. Enabler use is required to be voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques (link 1.2.7.5). Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint has been discussed as part of quality meetings.

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 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	The service undertakes a comprehensive programme of internal audits, which assist in identifying service shortfalls. Recent staffing changes resulted in corrective action plans not being developed for all identified shortfalls and not all corrective action plans that were developed being signed off as closed. Corrective actions have been developed and signed off for maintenance issues.	Eight of the thirteen internal audits that identified shortfalls in 2016 to date did not have a corrective action plan developed. Four of the five corrective action plans that were developed were not signed off as completed.	Ensure corrective action plans are developed when service shortfalls are identified and that these are signed off when completed. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service	PA Moderate	The in-service education programme includes a variety of topics, but does not include all learning and education	1. Staff training records demonstrate low attendance at staff training. For example: Restraint: 17/109 staff, infection	1. Ensure sufficient staff attend training sessions to ensure staff have the required knowledge and skills.

providers to provide safe and effective services to consumers.		requirements. Attendance at sessions is low. Different members of the management structure complete performance appraisals for those staff that report to them but not all had been completed. Five of seven staff files reviewed evidenced a completed annual appraisal.	control: 20/109 staff, Code of Rights: 10/109, Health and safety: 15/109 and pressure injury prevention and management 18/109. 2. Staff training has not been provided in the last two years around cultural safety, or falls prevention. 3. Two of seven staff files sampled did not have a current performance appraisal.	2. Ensure staff training is provided around cultural safety, abuse and neglect or falls prevention. 3. Ensure all staff have a current performance appraisal. 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	Medications are prescribed by the general practitioner and reviewed three monthly, however, not all medications had been charted correctly and documented the residents' allergy status. Medication competent staff sign for medication when administered. Not all medication was able to be evidenced to have been given as prescribed.	a) Seven of twelve medication charts sampled (two from the dementia unit, four from the hospital and one from the rest home), did not have signatures on the administration sheet to document that prescribed medication had been administered. Triangulation of evidence confirmed that medication had been administered but was not signed for at the time of administration. b) Three of twelve medication charts sampled (two dementia unit and one rest home) did not have allergies or nil known documented on the medication chart. c) One medication chart in the dementia unit did not have the route of administration documented for two medications	a) Ensure that medication signing sheets are signed at the time of administration. b) - c) Ensure that medication charts accurately document the prescribed route of administration and the residents' allergy status 30 days

			that have more than one potential route of administration. One rest home chart did not have the dose of the 'as required' medication documented.	
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 Low	InterRAI assessments were evidenced completed within 21 days of admission in all resident files sampled. In four of six files sampled (two hospital and two dementia care residents), the InterRAI assessment had been completed six monthly.	InterRAI assessments were not reviewed six monthly for two rest home residents.	Ensure assessments are completed within the required timeframes. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	Wound assessment, monitoring and wound management plans are in place for all wounds, however not all wound care documentation was fully completed or updated. Twenty-four hour diversional therapy care plans are completed for residents with dementia and challenging behaviours. These plans were generic and did not address the behavioural issues identified. Three of six care plans were evidenced to be updated to reflect the interventions required to meet the desired goals and outcomes. Wound assessment, monitoring and wound management plans are in place for all wounds	1. Issues around care planning: a) The care plan of a rest home resident with a diagnosis of diabetes did not document interventions for the management of hypo/hyper glycaemia; b) Risks associated with the use of restraint were not documented in two care plans for hospital residents requiring the use of a restraint; c) 24-hour diversional therapy care plans (two) for dementia level care residents did not document the distraction/de-escalation techniques that could be utilised to manage episodes of challenging behaviours; 2. Issues around wounds:	1.a) Ensure care plans contain the appropriate interventions to manage all health diagnoses; b) Ensure care plans document the risks associated with the use of restraint when in use; c) Ensure that 24 hour diversional therapy care plans for dementia residents describe the distraction/de-escalation techniques to prevent, minimise or manage challenging behaviours; 2. a) – d) Ensure that all wound documentation is fully completed to include description of wound, classification, timeframes for dressing changes, and that each wound has an individual assessment and treatment plan completed.

		however, not all wound care documentation was fully completed or updated.	a) Eleven of twenty-four initial wound assessments did not fully describe the wound; b) Seven of twenty-four wound management plans did not document the timeframe for dressing changes; c) Two hospital residents with multiple wounds did not have an individual assessment and treatment plan completed for each wound; and d) One pressure injury (hospital resident) was classified incorrectly and had been assessed as a stage-2 pressure injury. The wound photographs identify the wound as unstageable. The two pressure injury wound assessments did not document the stage of pressure injury being assessed and treated.	30 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	In the sample files reviewed, short-term care plans were evidenced to be utilised for infections and wounds. However, short-term care plans were not consistently used for acute changes in resident health status or updated in the long-term care plan.	a) A short-term care plan was not evidenced to have been completed for a rest home resident with significant unintentional weight loss in three months. A review of clinical risk assessments (nutritional, pressure injury or InterRAI) had not been completed; b) The long term care plan for a hospital resident had not been updated to reflect that the	a) Ensure short-term care plans are utilised for changes in resident healthcare or medical needs and a review of clinical risk assessments are completed when required; b) Ensure care plans are updated with changes to resident's care needs. 60 days

			resident no longer required the use of a lap belt as a restraint.	
Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.	PA Low	An outbreak commenced at Windsorcare the day following the previous clinical manager leaving and before the temporary clinical manager arrived. The general manager and a senior registered nurse managed the outbreak and maintained close contact with the DHB infection control team during the outbreak. Following the outbreak an infection control specialist met with staff and management to develop a future plan from lessons learned. The outbreak checklist in the infection control folder was not used as the staff available did not know about it. All infections are documented on monthly summary sheets and meeting minutes demonstrate analysis of this data.	No outbreak log was maintained and the service does not have records around how many staff or residents were affected.	Ensure an outbreak log is maintained. 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.

No data to display

End of the report.