

Otago Care Limited - Woodhaugh Resthome and Hospital

Introduction

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

The audit has been conducted by Health 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: Otago Care Limited

Premises audited: Woodhaugh Resthome and Hospital

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

Dates of audit: Start date: 20 August 2018 End date: 21 August 2018

Proposed changes to current services (if any): Following a refurbishment where existing rooms were converted to larger rooms, the total number of beds has reduced from 73 to 70. A further eight rest home rooms were verified at this audit as suitable to provide dual-purpose rest home and hospital beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 43



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

Woodhaugh rest home and hospital is privately owned. The service provides rest home and hospital (geriatric and medical) level of care for up to 70 residents. On the day of the audit there were 43 residents. Ongoing environmental improvements have occurred since the previous audit. Following a refurbishment where existing rooms were converted to larger rooms with ensuites, the total number of beds has reduced from 73 to 70.

This certification audit was conducted against 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 resident and staff files, observations, and interviews with family, residents, management, and staff.

This audit also included verifying the service as suitable to provide dual-purpose occupancy in a further eight rooms. This increases their current dual-purpose rooms from 31 to 39 rooms. The facility manager owns Woodhaugh and is supported by a clinical manager, a team of registered nurses and care staff. A number of improvements have been made to the environment and processes and systems since change of owner in 2017. Staff have policies and procedures in place to guide them in the safe delivery of care.

Areas for improvement identified at this certification audit are related to orientation, training, staffing, privacy of information, progress notes, timeframes for interRAI and care planning, care planning interventions, wound management, medication management, and completion of renovations.

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>Standards applicable to this service fully attained.</p>
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Information about services provided is readily available to residents and families. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) information is available. Policies are implemented to support rights such as privacy, dignity, abuse and neglect, culture, values and beliefs, complaints, advocacy and informed consent. Care planning accommodates individual choices of residents and/or their family/whānau. Residents are encouraged to maintain links with the community. Complaints processes are implemented, and complaints and concerns are managed appropriately.

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 owner is new to the facility manager role commencing in March 2018. He has previously worked in public service roles in Australia and New Zealand. He is supported by an experienced clinical manager who is new to the role in May 2018. The clinical manager has worked in aged care in management roles for five years and has worked in aged care in New Zealand for over seven years. She is supported by a resident relations manager, registered nurses and care staff.

The business plan has goals documented. Policies and procedures are appropriate to provide support and care to residents' rest home and hospital level needs. There is an implemented quality and risk management programme.

Staff receive ongoing training and there is a training plan developed and commenced for 2018.

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.
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The management team takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations.

Residents interviewed, confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

There are medication policies in place that comply with current legislation and guidelines.

Meals are prepared on-site. The menu is developed under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents 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.		Some standards applicable to this service partially attained and of low risk.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing and reactive maintenance issues are addressed. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a main lounge and dining area, and other smaller seating areas. The internal areas can be ventilated and heated. The outdoor areas are safe and easily accessible. Documented policies and procedures for the cleaning services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster. There are staff on duty with a current first aid certificate.

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.
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The service actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. There were no residents using enablers and no residents using restraint.

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 appropriate for the size and complexity of the service. The infection control nurse is responsible for coordinating and providing education and training for all staff. The infection control manual outlines the scope of the programme and includes a comprehensive range of policies and guidelines. The infection control nurse uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

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	37	0	3	5	0	0
Criteria	0	83	0	4	6	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Six residents (two hospital and four rest home, including one on a younger person's contract) and three relatives (two hospital and one rest home), confirmed that information has been provided around the Code of Rights. Residents stated their rights are respected when receiving services and care. There is a resident rights policy in place. Staff attend Code of Rights training. Discussion with five healthcare assistants and two registered nurses (RN) and the diversional therapist, identified they were aware of the code of rights and could describe the key principles of residents' rights when delivering care.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service has policies and procedures relating to informed consent and advanced directives. Seven resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Residents and families are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlets on entry. Resident advocates are identified during the admission process. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>The service has an open visiting policy and family/whānau and friends are encouraged to visit the home and are not restricted to visiting times. Residents interviewed confirmed that family and friends are able to visit at any time. Residents verified that they have been supported and encouraged to remain involved in the community where appropriate. There are regular outings into the community. Community groups visit the home as part of the activities programme.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaint forms are available. Information about complaints is provided on admission. The owner/manager, the clinical manager and the residents' relations manager operate an 'open door' policy. Residents and relatives confirmed they are aware of the complaints process. Healthcare assistants interviewed were able to describe the process around reporting complaints. There have been three complaints since the previous audit. One complaint is currently being investigated by Health and Disability commission. Documentation including follow-up letters and resolution, demonstrates that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed have been followed up and implemented. The service recently had a DHB issues-based audit, the report was not yet available.</p> <p>Discussions with residents and family members confirmed that any issues have been addressed and they feel comfortable to bring up any concerns.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service has information on The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) available at the main entrance to the facility. There is a welcome information folder that includes information about the code of rights. Residents and relatives confirmed they receive sufficient verbal and written information to be able to make informed choices on matters that affect them.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service provides physical and personal privacy for residents. During the audit, staff were observed treating residents with respect and ensuring their dignity is maintained. Care staff interviewed were able to describe how they maintain resident privacy. Staff attend privacy and dignity and abuse and neglect in-service as part of their education plan. Care staff interviewed stated they promote independence with daily activities where appropriate. Residents' cultural, social, religious and spiritual beliefs are identified on admission and included in the resident's care plan/activity plan to ensure the resident receives services that are acceptable to the resident/relatives.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is a Māori health plan and cultural safety and awareness policy to guide staff in the delivery of culturally safe care. The policy includes references to other Māori providers that are available and interpreter services. Management liaise with a local Iwi representative and the Māori liaison group at the DHB for any support or guidance required. There were no residents who identified as Māori on the day of audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service provides a culturally appropriate service by identifying any cultural needs as part of the assessment and planning process. Staff recognise and respond to values, beliefs and cultural differences. Residents are supported to attend church services of their choice and are supported to attend other community groups as desired.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff employment process includes the signing of an employment agreement that covers a code of conduct. Professional boundaries are defined in job descriptions. Staff were observed to be professional when carrying out their duties. Staff are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with care staff described how they build a supportive relationship with each resident. Residents and the relatives interviewed stated they are treated fairly and with respect by staff.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The staff are committed to providing a service based on the mission statement and philosophy of care. This was observed during the day with the staff demonstrating a caring attitude to the residents. The service has implemented policies and procedures that meet relevant standards. Registered nurses have access to external and internal education opportunities. Healthcare assistants have regular opportunities for internal education, however on interview, reported they are unable to access NZ qualification training through Woodhaugh (link 1.2.7.5). Facility meetings and shift handovers enhance communication between the teams and provide consistency of care.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed felt comfortable in approaching the facility manager, clinical manager or resident relations manager for any concerns. Residents have the opportunity to feedback on service delivery through two to three monthly resident meetings. Twelve accident/incident forms reviewed evidenced that relatives are informed of any incidents/accidents. Relatives interviewed stated they have been notified promptly of any changes to resident's health status.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required.</p>
<p>Standard 1.2.1: Governance</p>	<p>FA</p>	<p>Woodhaugh rest home provides residential services for up to 70 residents requiring rest home or hospital (geriatric or medical) level care.</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>There are 31 dual-purpose rooms and 39 rest home only beds (refer 1.4.2 in regards to dual-purpose beds). On the day of the audit, one wing (the upstairs wing) was not in use. On the day of audit there were 43 residents – 26 at rest home level care including one on a younger person with disability contract and one on respite care and 17 at hospital level of care including one on respite care (23 current dual-purpose rooms in use, and eight upstairs not in use).</p> <p>The audit included verifying a further eight resident rooms as suitable for dual-purpose (link 1.4.2). There is currently one resident that was re-assessed for hospital level care (May 2017) residing in a room that has not been verified as dual-purpose. The resident and her family have declined to move from that room. The room has easy access to both mobility toilet and shower and staff confirmed they can manage the resident.</p> <p>The non-clinical facility manager purchased Woodhaugh in October 2017 and took over the manager role in March 2018. The manager provides organisational oversight and management of the facility. He is supported by a clinical manager (CM) who has been in the role since May 2018 and a resident relations manager who has been in the role for 13 months. The CM has over 3 years' experience as a clinical nurse lead in aged care. The previous owner of the facility continues to have an interest in the property and is reported by staff and relatives (interviewed) to visit frequently.</p> <p>The goals and direction of the service are documented in the business plan.</p> <p>The manager has completed eight hours education related to the running of an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The manager reported that in the event of his temporary absence the resident relations manager and clinical manager jointly undertake this role with support other staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>FA</p>	<p>The manager facilitates the quality programme and ensures the internal</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>audit schedules are implemented. Corrective action plans have been developed, implemented and signed off when service shortfalls have been identified.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. All quality improvement data is discussed at monthly safety/quality/risk/staff meetings.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice. A document control system is in place. Policies are regularly reviewed. The manager is responsible for policy reviews with input from the clinical manager. There is also a quality consultant who acts as a clinical advisor including policy review. She is also still available for clinical support new policies or changes to policy are communicated to staff, evidenced in meeting minutes. There is a quality improvement plan in place for 2018. Goals and progress towards meeting these are discussed at staff meetings. There is a current risk management plan.</p> <p>The health and safety officer (CM) is transitioning into the role and is supported by the facility manager. The FM has completed external health and safety training. The hazard register is stored on-line and includes required actions and regular reviews. The on-line register is available for all staff to view, however the manager stated he plans to post on staff noticeboards to increase staff awareness.</p> <p>There are resident and relative surveys conducted and analysed with corrective action plans developed when required. The June 2018 resident survey demonstrated satisfaction in most areas. Individual concerns were addressed. A corrective action plan identified that improvements are being addressed in areas where results were sub-optimal.</p> <p>Falls prevention strategies include an investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. Other strategies include sensor mats, and regular checks on residents at risk of falling.</p>
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<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 accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents on an electronic database. Incident/accident is entered by staff that have either witnessed an adverse event or were the first to respond. The RN on duty is contacted for a clinical review of the resident following an adverse event. Twelve incidents sampled for August 2018 demonstrated appropriate documentation and clinical follow-up including neurological observations. Accidents and incidents are analysed monthly with results discussed at quality/clinical/staff meetings.</p> <p>The facility manager is aware of situations that require statutory reporting. There have been no outbreaks since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>Nine staff files sampled (the clinical manager, three registered nurses, the resident relation manager, diversional therapist and three healthcare assistants) showed appropriate employment practices and documentation. Current annual practicing certificates are kept on file.</p> <p>New staff are expected to be buddied with experienced staff for an orientation period of up to three days or longer if required. Staff interviewed reported that at times orientation occurs over one day rather than three as planned, and that suitably experienced staff are not always available to provide orientation. The orientation checklist is completed by the new staff and their preceptor and reviewed by the clinical manager. The orientation package provides information and skills around working with residents with aged care needs, however this was not always evidenced as completed in all staff files sampled.</p> <p>There is an annual training plan in place and implemented that has included, (but not limited to), challenging behaviour, infection control, death and dying, manual handling, prevention and management of abuse and neglect, residents' rights, cultural sensitivity, falls prevention and pressure injury prevention and management. Staff files sampled contained a current annual performance appraisal for those staff who had been employed for a year or more.</p>

		<p>The service reports a high staff turnover and is continuing to implement strategies to manage with this. As previously, management advised that much of that has been to do with immigration and RNs moving on. Relatives and staff interviewed reported on the difficulties presented by the staff turnover.</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>PA Low</p>	<p>There is a staffing policy that includes staff skill mix. The service reports a high staff turnover of inexperienced staff, particularly in relation to registered nurses. Proposed rosters differed from worked rosters. Amendments to the working roster can be changed by overwriting existing information. The changes cannot be tracked unless the employee has requested the change with an associated paper trail. Actual rosters sighted, and staff, resident and family feedback demonstrated that there are times when there are insufficient staff rostered to complete all required tasks. There is a registered nurse on duty at all times. There are currently six RNs (four full-time, one part-time and one casual) employed at Woodhaugh and only two full-time staff are interRAI trained. This was confirmed by rosters, and registered nurse interview. The facility manager (non-clinical) and the clinical manager are on call at all times. If for any reason the clinical manager cannot be contacted the quality control advisor is available 24/7. The manager creates the rosters with input from the clinical manager. The quality control advisor is an RN and has been involved with the service for many years. She is not based at Woodhaugh but can be contacted by phone at any time. There are sufficient RN hours rostered to meet the needs of the current residents.</p> <p>Registered nurses work either eight or twelve-hour shifts and are rostered 24/7. At times additional RN morning hours are rostered to assist with documentation requirements. The clinical manager works from 8.00 am to 4.30 pm Monday to Friday and is back on full time after recent leave. At the time of the audit there were 43 residents (26 rest home and 17 hospital level care). The actual HCA roster worked for a week was compared with the proposed roster.</p> <p>The worked roster number and time of morning shifts varied from day to day. A sample was as follows: Morning shift there were three HCAs from 7.00 am to 3.00 pm. Afternoon shift two HCAs on 3.00 pm to 11.00</p>

		<p>pm, one from 3.00 pm to 8.30 pm, and one from 4.00 pm to 9.30 pm. Night shift is covered by an RN and two healthcare assistants. If changes are made to the roster, this is updated on line either at the time or the next working day. There is no paper trail of changes, however the actual roster can be compared with the proposed roster. Different colours in the roster are used for different roles. Staff who were rostered to work and did not complete their shifts are required to apply for leave in order to receive sick or bereavement leave payments. At times, staff share their shift with two or more roles. All roles are colour coded with start and end times and this is clearly identified on the roster.</p> <p>There are rostered cleaner shifts. Laundry is completed off-site. Healthcare assistant position descriptions document appropriate care and support tasks. There is a cook and two kitchenhands rostered on each day to prepare meals and wash dishes, including cleaning the bain marie.</p> <p>The staff are supported by a resident relations manager who assists in arranging resident appointments, ensuring family contact is maintained and residents personal grooming needs are met.</p> <p>Residents, family members and staff reported a high work load with a high turnover of new inexperienced staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Moderate</p>	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are electronic.</p> <p>All staff have individual log-in details and access levels are assigned according to role defined guidelines as sighted. Roles were grouped for each employment group, (eg, RN, HCA, CM, FM, cleaner, cook, GP, podiatrist etc). Areas of access were defined for resident care, rosters, employees, enquiry, security, hazards, goals, training and many others. Non-clinical staff with either full, administration or read only access to all resident areas of the system include the quality control coordinator, director, administrator/data entry (admission only), and the resident relations manager. On the day of audit not all access levels evidenced that role permissions had been set up according to the documented</p>

		<p>access levels. An external provider manages the database, back-up and security. On-site system testing of each access level has not been completed. Individual resident files sampled, demonstrated service integration. Medication charts are completed using a secure electronic management system.</p> <p>Electronic progress notes and care plans are in the electronic database and are legible, dated and identified to the relevant staff member including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has policies and processes in place around the admission process. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. Residents and relatives interviewed, confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the service. Seven signed admission agreements were sighted. The admission agreement form in use aligns with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs reported that they include copies of all the required information in the envelope.</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>	PA Moderate	<p>Fourteen medication charts were reviewed including one paper-based chart for the respite resident. There are policies available for safe medicine management that meet legislative requirements. The service uses an electronic medication management system for long-term residents for other short-term residents. The medication charts reviewed did not all identify that the GP had seen and reviewed the resident at least three-monthly.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Registered nurses interviewed could</p>

		<p>describe their role regarding medication administration. Administration records demonstrated that not all medications were administered as prescribed. All medications are checked on delivery against the medication chart as documented on the electronic system.</p> <p>Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>The medication room was clean and secure, but there were expired medications in stock. The medication trolley was clean, and all eye drops dated. The medication fridge temperature is recorded regularly and is within the acceptable ranges.</p> <p>Staff observed during the medication rounds demonstrated safe practice. The morning round for the first day of audit took two and a half hours and the lunch round one hour.</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>	<p>FA</p>	<p>All meals are prepared and cooked on-site by the cook and kitchenhand. There is a four-weekly seasonal menu in place, which was reviewed by a dietitian in July 2018. The kitchen is informed of resident dietary needs and changes. Likes and dislikes are accommodated. Additional or modified foods such as soft foods, pureed and vegetarian meals are provided. If required, changes are made to the menu, however this is not currently documented. Food is taken from the kitchen in bain marie containers and served in the dining room by care staff. The food service was included in the recent resident survey and results had evidenced improvement on previous audits. Residents and family members interviewed were complimentary about the meals provided.</p> <p>The main kitchen is adjacent to the dining room where all meals are prepared. Meals are plated and served to residents in the dining room. A current food control plan is in place. Fridge and freezer temperatures are monitored and recorded daily. All containers of food stored in the pantry are labelled and dated. All perishable goods are date labelled. A cleaning schedule is maintained.</p> <p>The meals served on the two days of audit matched the menu plan approved by the dietitian.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	The reason for declining service entry to prospective residents to the service is recorded. Should this occur, the manager team stated it would be communicated to the potential resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or if they could not meet the service requirements.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	The RNs complete an initial assessment on admission, including risk assessment tools as appropriate. The electronic care planning system utilises a range of assessment tools to develop the care plan. An interRAI assessment is undertaken six monthly or earlier, due to health changes for long-term residents (link to 1.3.3.3). Resident needs and supports are identified through the ongoing assessment process in consultation with the resident and significant others and form the basis of the long-term care plan (link 1.3.5.2).
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	The care plans reviewed were resident-focused. The interRAI assessment process and assessments as part of the electronic care planning system inform the development of the resident's care plan. Residents and their family/whānau interviewed, reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. The care plans reviewed did not all describe the support required to meet the residents' goals and needs and identified allied health involvement (link 1.3.6.1). The short-term respite resident's care plan described the care and support needed for the short-term admission. The care plan for the younger person documented interventions associated with a younger person, but not all interventions to support the medical condition.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to</p>	PA Moderate	When a resident's condition alters, the RN initiates a review and if required, GP, however not all residents had specialist input to care where required. There is evidence that family members were notified of

<p>meet their assessed needs and desired outcomes.</p>		<p>any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. The hospice nurse commented on the improvement to care and support over the year and the close liaison and willingness to work with the palliative service.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and evaluations on change of dressings were in place for three residents; two with minor wounds one with a chronic wound. The three wounds did not have a documented wound management plan. There were no residents with pressure injuries.</p> <p>Continence products are available. The residents' files include a urinary continence assessment, bowel management plan, and continence products used.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours (link 1.3.5.2).</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs a diversional therapist who works 35 hours per week and an activities coordinator Monday to Friday. A wide range of activities addressing the abilities and needs of different residents (rest home and hospital) are offered, and the attendance rate is high, with residents of different abilities being supported to enthusiastically join in the activities.</p> <p>A wide range of group activities are offered, many at the suggestion of residents. Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. Examples include; the walking club, concerts, school visits, arts and crafts, card games and exercise and music. The younger person disabled resident loves art, and the service encourages this and exhibits the art in an exhibition.</p> <p>On admission, the diversional therapist completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the</p>

		<p>residents condition determine) as part of the care plan evaluation/review.</p> <p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement. The diversional therapist has current first aid certificates.</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 registered nurses evaluate all initial care plans within three weeks of admission. Care plans sampled demonstrated that the long-term nursing care plan was evaluated at least six-monthly or earlier if there is a change in health status (link 1.3.5.2). There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents and/or their family/whānau are involved as appropriate when a referral to another service occurs. Registered nurses interviewed, described the referral process should they require assistance (link to 1.3.6.1 and 1.2.8.1).</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed.</p> <p>Chemicals were secured in designated locked cupboards. Chemicals were labelled, and safety datasheets were available throughout the facility and accessible to staff. Safe chemical handling training has been provided. Gloves, aprons, and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties.</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>PA Low</p>	<p>There is a current building warrant of fitness that expires 19 February 2019. The facility employs a maintenance person to undertake maintenance and a gardener/cleaner who maintains the grounds. Daily maintenance requests are addressed, and a 12-monthly planned maintenance schedule is in place. Electrical testing has been completed within the last year. Annual calibration and functional checks of medical equipment is completed by an external contractor.</p> <p>Hot water temperatures in resident areas are monitored monthly. Contractors are available 24 hours for essential services.</p> <p>The facility has a number of lounges and areas with sufficient space for residents to safely mobilise using mobility aids.</p> <p>Residents were observed to safely access the outdoor gardens and courtyards. Seating and shade are provided.</p> <p>The care staff interviewed, stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>A partial provisional in 2014, verified 23 resident rooms across three wings (Millhouse wing -eight rooms; The Villa wing -nine rooms and Homestead wing -six rooms as appropriate for providing hospital level care. These three wings are situated on the ground floor. A further eight rooms in Gables wing upstairs was verified as suitable, subject to a mobility toilet being installed.</p> <p>Since change of ownership in 2017, the service has installed a new nurse call system. They have also renumbered all rooms and the layout was simplified. Villa and Homestead wings were combined to form the South wing with room numbers from 1 to 30 inclusive. Millhouse and Inverleigh wings now form North wing with room numbers 31 to 53 inclusive. Gable wing (upstairs) is now called level one and consists of rooms 54 to 70.</p> <p>The room numbers under a revised number system are;</p> <p>South wing – Rooms 2, 3, 4, 5, 6, 7, 8, 11, 14, 15, 17, 18, 19, 21 and 28. (15 rooms as dual-purpose)</p> <p>North wing – 31, 35, 36, 37, 38, 40, 41 and 45 (8 rooms dual-purpose). The previous partial provisional did not identify any Inverleigh rooms as</p>
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		<p>dual-purpose rooms. As part of this audit, the rooms in this wing were verified as large enough for hospital residents and there is one communal shower suitable for hospital residents. The service has completed renovations and five toilet ensuites have been installed which are suitable for dual-purpose (Rooms 46, 50, 51, 52 and 53). There is a staff assigned toilet in this wing that will be reassigned as a resident toilet which rooms 47 and 48 could utilise). Therefore, a further seven rooms (46, 47, 48, 50, 51, 52 and 53) in North wing have been verified as suitable for dual-purpose. Therefore, the total number of rooms in North wing dedicated as dual-purpose is 15 rooms.</p> <p>Level One – 59, 60, 61, 62, 63, 64, 65, and 66 (eight rooms as dual-purpose). A further room on level one (room 58) has been verified as suitable to provide hospital level care. A mobility toilet has been installed on level one. The upstairs is not currently in use and is under renovation. There are a number of different levels on level one that has to be managed by residents via ramps or stairs. The ramps have a steep gradient which makes it difficult for mobility equipment. Not all floors and rooms on the upper floor are fully renovated and the area is not currently heated. The service is over two levels and has a lift between floors. Residents transported in the lift need to be in a chair as the lift does not fit a trolley or bed.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Some resident rooms have ensuites, and for other residents there are communal toilets located close to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff are undertaking personal cares. Bathrooms designated for rooms for hospital level residents can accommodate a resident transported on a shower chair (or equivalent).</p> <p>There are two of three communal showers and one of five toilets in North wing (previous Millhouse) which are large enough for usage of mobility equipment. There are ensuite toilets, a communal toilet and mobility shower within North wing (previous Inverleigh) suitable for mobility equipment. There is a mobility shower/toilet on level one (link 1.4.2.1).</p> <p>There are four mobility bathrooms in south wing (previous Homestead</p>

		and The Villa) suitable for hospital level residents.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids, including the rooms designated for hospital level. Residents are encouraged to personalise their bedrooms, and this has occurred.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	The facility has a large lounge/dining area for the rest home and hospital residents, which is divided into a number of areas for dining and seating placed to allow for individual or group activities. There are also two other large lounge areas and a number of smaller lounges throughout the facility.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	There are policies/procedures and audits of the cleaning and laundry service. There are dedicated cleaning staff on duty each weekday and caregivers also complete cleaning tasks. All linen and personal clothing is laundered off-site and collected six days per week. There is a locked disused laundry, which is used to store chemicals along with clothing and linen awaiting pickup for laundering.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There are policies and procedures on emergency and security situations, including how services will be provided in health, civil defence or other emergencies. All staff receive emergency training on orientation and ongoing. The fire evacuation scheme was updated and approved by the fire service 6 January 2017. There are six monthly fire drills with the last drill being undertaken 28 June 2018.</p> <p>There is a staff member with a first aid certificate on each shift. A recently updated call bell and pager system with call bells in resident rooms, communal bathrooms and living areas, alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources were available. Sufficient water is</p>

		stored for emergency use and alternative heating and cooking facilities are available. Emergency lighting is installed. Electrical testing and calibration of all medical equipment has been completed in June 2018. Security checks have been conducted each night by staff.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. A registered nurse is the infection control coordinator. She has a job description that outlines the responsibility of the role. The infection control coordinator is responsible for the collation of infection events and reporting to the combined infection control team/staff meeting monthly. The infection control programme was last reviewed in May 2018. The facility has access to professional advice and has developed close links with the GPs, community laboratory, the public health department and the local district health board (DHB). There have been no outbreaks since the last audit. Sufficient supplies of provisions to manage infection control including liquid soap in all rooms and plentiful supplies of hand gel were sighted.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has been in the role for ten months and has completed the MoH on-line infection control course. The infection control team (infection control coordinator, clinical manager, RNs, health care assistant, diversional therapist and kitchenhand) meet monthly after the clinical meeting to discuss surveillance results, planned training. The infection control coordinator is supported by the clinical manager. The infection control coordinator has access to GPs, laboratory service,

		the infection control nurse specialist and public health departments.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies are developed and reviewed in consultation with an external infection control consultant.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The IC nurse has completed external on-line training. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and annually. Infection control is discussed at handovers with care staff. Health care assistants interviewed could describe standard precautions for the prevention of infection.</p> <p>Resident education is expected to occur as part of providing daily cares as appropriate.</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>Systems in place are appropriate to the size and complexity of the facility. There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is logged onto the electronic system and a monthly report is generated and relevant information is given to staff. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>Infection control data is discussed at monthly staff meetings. Monthly and annual comparisons are made for the type and incidence of infection rates. Internal audits for infection control are included in the</p>

		<p>annual audit schedule.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. Staff have received training around managing behaviours that challenge.</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)
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	A comprehensive orientation programme is implemented for all new staff and includes a checklist as evidence of completion, however not all staff files demonstrated that the orientation process was fully completed. Staff reported that at times suitable experienced staff are not available to provide the orientation for new staff.	Two staff (one RN and one HCA) employed in January or February this year did not have completed orientation checklists on file. Following the draft report, the manager advised that this has been addressed.	<p>Ensure that staff files evidence that all staff have fully completed the orientation programme.</p> <p>90 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</p>	PA Low	In-service education opportunities are planned and provided for all staff, however this does not currently include access to NZQA standards.	There is no current provision or system in place for staff to access NZQA qualifications standards.	Implement a process to enable staff to access NZQA qualifications relevant to their employment.

to consumers.				180 days
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Proposed rosters were compared with the actual worked roster for the two weeks prior to the audit. While the service has made improvements to staffing, there continues to be feedback from staff and relatives about staff turnover and staffing levels. However, all residents and relatives interviewed did report the positive changes being made by the new owner and that staff that were rostered were very caring. All care staff interviewed stated that RNs were readily available and responsive to all requests. Care staff reported that agency staff are not used at Woodhaugh.</p>	<p>Interviews with management and review of rosters identified the service has made improvements to staffing and increased staffing hours since last audit. Rosters sighted evidenced adequate cover to support current residents. However, concerns about turnover of new staff, and staffing levels including answering bells in a timely manner were identified in interviews with three caregivers, four of six residents and two relatives. During the audit a call bell was not answered in a timely fashion as the assigned staff member was on a break and there was no designated cover. Advised that the staff member did not follow correct procedure around breaks and this was addressed.</p>	<p>Ensure there call bell response time is monitored and answered in a timely manner</p> <p>Ensure staffing levels are continually reviewed and monitored with staff.</p> <p>60 days</p>
<p>Criterion 1.2.9.7</p> <p>Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.</p>	PA Moderate	<p>The electronic resident management system includes designated role access permissions. The software developer is responsible for ensuring system administration is managed according to the facility requirements. Access permissions as viewed, are defined for resident levels. Access levels were documented in sufficient detail to confirm all access levels are appropriate to the service delivery. One of three access levels randomly</p>	<p>Two of three access levels checked, allowed access contrary to planned permissions: i) An RN access level allows access to all employee information including other RNs personal file information such as reference checks and recruitment details. ii) The HCA with 'read only' access according to role permissions, had access to edit and delete care plans.</p>	<p>Ensure all access levels are tested and confirmed as meeting the access permissions template.</p> <p>60 days</p>

		checked, confirmed access as documented. The facility manager, once aware of the RN and HCA access levels immediately logged the issue with the programme provider and changes were made on the day of audit.		
<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA Moderate</p>	<p>The service uses an electronic medication documentation system for long-term residents. Short-term residents have paper-based documentation. The respite resident's paper-based medication chart sampled had been documented by the residents own GP and met legislative standards. Not all long-term resident files had been documented as reviewed by the GP three monthly. The medication room was clean and well organised; however, some medication was out of date. The medication round observed followed good practice, but a review of signing charts did not document that all medication was signed as given.</p>	<p>i) Of all the medication charts on the electronic system (42 - one was paper based), seven were overdue for a three-monthly medication review. The clinical leader is working with the GP to ensure they complete this when they undertake the three-monthly resident reviews.</p> <p>ii) The medication cupboard included four expired antibiotics for injection.</p> <p>iii) Three of the 13 electronic medication chart signing sheets documented 'dose supplied' with no documentation to evidence that the medications had been taken.</p>	<p>i) Ensure that the GP documents the three-monthly medication reviews on the medication charts.</p> <p>ii) Ensure that all medication is within date.</p> <p>iii) Ensure that all medication administered is taken.</p> <p>30 days</p>
<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</p>	<p>PA Moderate</p>	<p>Of the six long-term files reviewed, only one had been admitted within the last year. The sample was extended by two further files to confirm timeliness of processes for new admissions. Two of the three files did not have a long-term care plan or</p>	<p>Two of three admissions for 2018 did not have the initial interRAI assessment and long-term care plan documented within set timeframes</p>	<p>Ensure that admission timeframes are adhered to for interRAI and care planning</p> <p>90 days</p>

consumer.		interRAI within set timeframes. The clinical manager has documented a plan and calendar to address this shortfall prior to the audit.		
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Moderate	<p>Progress notes are documented in the electronic resident management system by all staff. The system records the time and date and person, including designation of the staff member completing the entry. Healthcare assistants are required to document in the electronic progress notes each shift, and RNs at least daily in hospital residents' notes and weekly in rest home resident notes. Five of seven files reviewed progress notes were documented regularly.</p>	<p>Progress notes were not consistently documented for two of seven resident files reviewed</p>	<p>Ensure progress notes are documented at required intervals</p> <p>90 days</p>
<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 Moderate	<p>Registered nurses are responsible for developing resident care plans and all residents had a care plan documented on the electronic system. Staff informed that they can easily access the care plans. The care plans reviewed did not all describe the support required to meet the resident's goals and needs and identified allied health involvement. The respite care plan and the care plan for an end of life care resident (hospital level) documented identified needs.</p>	<p>Two hospital level files did not identify all resident needs; (i) Resident one; did not include care and support for BIPAP, an indwelling catheter that regularly blocks or a preference for sleeping in a chair. (ii) Resident two had an up to date interRAI for a recent change of care level (rest home to hospital) but the long-term care plan had not been updated to reflect the care needs.</p> <p>Two rest home files did not identify all resident needs. (i) Resident one did not include falls interventions and behaviour management interventions when the resident was intoxicated.</p>	<p>Ensure care plans document interventions for all identified resident needs</p> <p>60 days</p>

			(ii) Resident two (YPD) did not include interventions for behaviours that challenge, management of pain, recognition and management of epilepsy.	
<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>	<p>PA Moderate</p>	<p>All residents have a care plan in place, the new clinical manager has made significant progress with ensuring assessment and care needs are documented in a timely manner. Wounds did not document a management plan and two residents with more complex needs did not have a specialist review.</p>	<p>(i) One rest home resident with significant behaviours that challenge over a period had no documented specialist review such a mental health for older people. (ii) One resident with a chronic wound did not have specialist review from the wound care nurse. (iii) Three wounds did not have a documented management plan.</p>	<p>(i)-(ii) Ensure that specialist input is sought for care as needed. (iii) Ensure that all wounds have a documented wound management plan.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There is a current building warrant of fitness that expires 19 February 2019. There is a preventative and reactive maintenance programme in place. The upstairs area (level one) is not currently in use as it is in the process of refurbishment.</p>	<p>The renovation of the upstairs area is not complete, examples include: flooring for toilet and other areas, accessible ramps and heating.</p>	<p>Complete the renovation of the upstairs area; flooring for toilet and other areas, accessible ramps and ensure heating prior to admission of hospital residents (and rest home residents)</p> <p>Prior to occupancy days</p>

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.