

Whangaroa Health Services Trust - Whangaroa Health Services

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Whangaroa Health Services Trust

Premises audited: Whangaroa Health Services

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

Dates of audit: Start date: 26 September 2018 End date: 27 September 2018

Proposed changes to current services (if any): The service has added one extra bed (dual purpose). This bed has been added to a room that previously housed four beds but has only been used as a three-bed unit. The room is now being used as a four-bed unit. Bed numbers have increased from 24 to 25 (15 dual purpose and 10 rest home).

Total beds occupied across all premises included in the audit on the first day of the audit: 24



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Whangaroa Health Services is governed by a trust board, comprised of representatives from the local community. The service provides care in Kauri Lodge for up to 25 residents at hospital and rest home level care.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The service is managed by an interim general manager, who is an experienced health services manager. He is supported in the role by a clinical manager(RN), who has been in the role for three years and a non-clinical support services manager.

Residents and families interviewed commented positively on the standard of care and services provided.

Three of eight shortfalls identified as part of the previous audit have been addressed. These are related to; complaints management, medications management and the food service. There continues to be improvements required around the quality system management and follow up, education for staff, implementing care and the infection control annual review.

This audit has identified a further five areas requiring improvement around family communication, hot water temperatures, first aid qualified staff, timeliness of assessments and care plans and activities documentation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Some standards applicable to this service partially attained and of low risk.

Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

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.

There is a business plan with goals for the service that has been regularly reviewed. The service is in the process of implementing a new quality and risk system. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme. A training programme that provides staff with relevant information for

safe work practices is in the process of implementation. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with 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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There is 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.
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The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were four residents using restraints and one enabler at the time of the audit.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	8	0	5	4	0	0
Criteria	0	33	0	5	5	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints' register. The service is in the process of implementing an online complaint recording system, all new complaints are now to be registered on to the online system. Older complaints are paper-based.</p> <p>There have been three complaints since the previous audit; two have been resolved and one is currently being investigated and followed up by the interim general manager. All complaints have been actioned within set time frames. This is an improvement from the previous audit.</p> <p>A Health and Disability complaint dated January 2018 records no further action, the DHB has also investigated this complaint and an investigation and action plan have been documented and followed up.</p> <p>All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents (three rest home and one hospital) and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</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>PA Low</p>	<p>There is a policy to guide staff on the process around open disclosure. The clinical manager confirmed family are kept informed. Relatives (two hospital) stated they are advised of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through open-door communication with management. A survey for 2018 is currently in progress.</p> <p>Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed did not always evidence that relatives are informed of incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Whangaroa Health Services is governed by a trust board, comprised of representatives from the local community. The service provides care in Kauri Lodge for up to 25 residents at hospital and rest home level care. On the day of the audit, there were 24 residents. There were 18 residents at rest home level, including one younger person disabled and one long-term resident under the long term chronic condition contracts (LTS-CHC). There were six residents at hospital level care including one long-term LTS-CHC funded resident. All other residents were under the age-related residential care services agreement.</p> <p>As part of this audit a large room (currently has three beds) was verified as suitable to have an extra dual-purpose bed to make it a four-bedded room. This will increase total bed numbers from 24 to 25 (15 dual purpose and 10 rest home).</p> <p>The service is managed by an interim general manager, who is an experienced health services manager. He is supported in the role by a clinical manager (RN) who has been in the role for three years and a non-clinical support services manager. The clinical manager is responsible for the care home only with a separate registered nurse employed for the adjoined health centre (GP centre).</p> <p>There is a business and quality plan in place, the interim GM provides a monthly service management report to the board.</p> <p>The interim general manager and clinical manager have completed at least eight hours of professional development activities related to managing a rest home and hospital.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>PA Moderate</p>	<p>Since the previous audit the service has purchased a quality system from an external consultant. The new system is robust and has processes to guide staff around quality data gathering including (but not limited to); collection, collation and reporting incidents/ accidents, complaints, infection control, restraint and addressing</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>issues raised from internal audits. The system is not yet fully implemented. There continues to be improvements required around completing internal audits, reporting to meetings, and signing off corrective actions. These are repeat shortfalls from the previous audit.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (two healthcare assistants, one RN, a diversional therapist, maintenance and the cook) confirmed they are made aware of any new/reviewed policies. Staff sign to confirm they have read the polices. There are clinical policies/procedures to support hospital and rest home level care.</p> <p>Service meetings include; a monthly clinical quality meeting, a monthly staff meeting, a monthly resident's meeting and a two monthly Health and Safety meeting. Meeting are held as scheduled.</p> <p>There is a health and safety and risk management system including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service collects incident and accident data and enters them into an electronic register. The system provides monthly reports, which are discussed at the monthly CQI and staff meetings (link 1.2.3.6).</p> <p>There were 11 resident-related incident forms documented for August, eight of which were falls. Seven of the eight falls-related incidents were reviewed for August and one Pressure injury related incident form for June. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk, neuro observations have not consistently been completed (link 1.3.6.1). The healthcare assistants interviewed could discuss the incident reporting process. The clinical manager collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>The clinical manager interviewed could describe situations that would require reporting to relevant authorities. There have been no notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are</p>	<p>PA Moderate</p>	<p>There are human resources management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept.</p> <p>Five staff files were reviewed (one clinical manager, two registered nurses and two healthcare assistants)</p>

<p>conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>and evidence that reference checks were completed before employment was evidenced. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service. Staff appraisals were evident in all staff files reviewed. This is an improvement from the previous audit.</p> <p>The in-service education programme for 2017 has not been fully implemented and a training calendar for 2018 (YTD) was unable to be evidenced. Meeting the ARCC requirements of providing eight hours of training annually is an area that continues to require improvement. Staff training provided has included pressure injury prevention (March) and infection control (June) with low attendance. Advocacy was provided September 2017 with 20 staff attending. The service has plans to implement the training schedule provided by the new quality contractor and this schedule was published for staff in preparation.</p> <p>The clinical manager and registered nurses can attend external training. The service has access to online learning for staff, but it was unclear how many staff had accessed this training. Two of six registered nurses have completed interRAI training.</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>Whangaroa Health Care has a roster in place which provides sufficient staffing cover for the provision of care and service to residents, however there is not a recognised first aid staff member on each shift. Since the previous audit, the clinical manager was required to provide oversight to the health centre (attached to the rest home) as well as the rest home/hospital. The interim GM has recently employed an RN specifically for the health centre, this has now freed up the clinical manager to provide full-time management and oversight to the rest home/ hospital.</p> <p>The following staffing roster was in place for 24 residents (18 rest home and six hospital level).</p> <p>A clinical manager (RN) Monday to Friday and on call</p> <p>A registered nurse each shift Monday to Sunday, plus additional shifts for interRAI RNs as needed.</p> <p>AM; There are two healthcare assistants on long shifts and one on a short shift.</p> <p>PM; There is one healthcare assistant on a long shift and two on short shifts.</p> <p>Night; There is one healthcare assistant to support the rostered RN.</p> <p>A diversional therapist is employed four days a week. Additional staff are employed for housekeeping, laundry and kitchen.</p> <p>The staff interviewed advised that additional staff can be rostered on to meet the needs of the residents.</p> <p>Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of</p>

		residents
<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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. Since the previous audit the service has implemented an electronic medication system.</p> <p>Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses who have passed their medication competency administer medications. Medication competencies are updated annually, and staff attend annual education. There are no standing orders. The medication fridge temperature is checked daily. Eye drops are dated once opened.</p> <p>Ten medication charts were reviewed. Medications have been reviewed at least three-monthly by the GP. All electronic medications charts included photo ID, allergy status and as required' medications all had indications for use charted. This is an improvement from the previous audit.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service employs two cooks. Both have current food safety certificates. There is a well-equipped kitchen and all meals are cooked on-site. Meals are served directly from a bain marie to both dining rooms. Special equipment such as lipped plates are available. On the day of audit, meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Internal audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked for all hot meals. These were all within safe limits. Re-heated meals also have temperature checks, this is an improvement from the previous audit.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The four-weekly menu cycle is written and approved by an external dietitian. The food control plan is in the process of being verified.</p> <p>All residents and family interviewed were very happy with the meals provided. There were bowls of fruit available in the dining room for residents to help themselves.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	PA Moderate	<p>Care plans sampled were goal orientated. The care staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>frequently where necessary.</p> <p>There were three wounds logged on the register at the time of the audit. One resident had a grade two pressure injury. Assessments, management plans and documented evaluations were not clearly documented for all wounds. This is a continued shortfall from the previous audit.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available two days during the week to assist with mobility assessments and the exercise programme.</p> <p>Monitoring records sighted (blood sugar monitoring, neuro observations, food and fluids and turning charts) were not consistently completed. This is a continued shortfall from the previous audit.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Moderate</p>	<p>There is one diversional therapist (DT) who works 32 hours a week over four days. Caregivers were observed talking with residents and some residents were watching the television. There is a large whiteboard in the hallway and the monthly programme is documented on this. Residents have the choice of a variety of activities in which to participate. These include (but not limited to) exercises, Tai Chi, walks outside, gardening, games and quizzes.</p> <p>Those residents who prefer to stay in their room have one-on-one visits. The DT also provides residents books, puzzles or crosswords.</p> <p>There are fortnightly church services and the nuns visit weekly to give communion.</p> <p>Not all residents had an activity plan or activity assessment documented. Activity plans (where in place) are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents are reassessed using the interRAI process or if there has been a significant change in their health status. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews are signed as completed by the RN. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home residents and one-monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>PA Low</p>	<p>The building holds a current warrant of fitness. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>Electrical equipment has been tested and tagged. Hot water temperatures have been monitored randomly in resident areas but were not always within the acceptable range. The communal lounges are carpeted. The hallways and utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted and ensuites, communal showers and toilets have nonslip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained.</p> <p>As part of this audit a large room (currently has three beds) was verified as suitable to have an extra dual-purpose bed to make it a four-bedded room. This will increase total bed numbers from 24 to 25 (15 dual purpose and 10 rest home). There is enough space for mobility equipment, a call bell is in situ and curtains available for privacy.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	<p>PA Low</p>	<p>Whangaroa Health Services has implemented a new infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The clinical manager is the designated infection control coordinator with support from all staff members of the infection control team. Overall infection control is discussed at staff meetings (link 1.2.3.6). Minutes are available for staff. Spot infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has not been reviewed annually. This is a continued shortfall from the previous audit.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Whangaroa Health Service's 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 with results reported to the monthly staff meeting (link 1.2.3.6). Reports are easily accessible to the CEO and clinical services manager. There have been no outbreaks since the previous audit.</p> <p>The service was able to show actions taken following a spike in urinary tract infection, these included a review of cleaning products, training for staff and monthly hand washing checks.</p>
<p>Standard 2.1.1: Restraint minimisation</p>	<p>FA</p>	<p>The facility has restraint philosophy aiming at being restraint-free. There are restraint minimisation and safe practice policies and procedures in place. There is a restraint and enabler register. There is a designated restraint 'champion'. When interviewed the clinical manager reiterated the facility's no or minimal restraint</p>

Services demonstrate that the use of restraint is actively minimised.		philosophy. There are currently four residents with bedrail restraint and one resident with an enabler. Appropriate assessments and consents were documented.
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	The service has an incident reporting process in place. The forms have the facility to document if family have been informed, however incident forms reviewed did not all identify family/NOK were informed.	Six of seven incident forms reviewed did not document is relatives had been informed following an incident or accident.	Ensure that relatives/ EPOA are documented as informed following incidents and accidents. 90 days
Criterion 1.2.3.6 Quality improvement data are collected,	PA Moderate	The service is in the process of implemented a new quality system. Incidents and accidents, and infection control have been documented and a trend analysis undertaken. This is an	(i)Not all audits have been completed as scheduled; Examples include; the education audit May 2018, the medication audit June 2018, and no audits were documented as undertaken in July 2018. (ii) Quality outcomes are not consistently documented as reported to	(i)Ensure that Internal audits are undertaken as scheduled; (ii) – (iii)

analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		improvement from the previous audit. The quality contractor for the new system is available to the service for advice and support. Not all aspects of the new quality system are fully implemented, and this continues to be an area requiring improvement.	meetings; Example; the staff meeting August 2018 did not document incidents and accidents or infection control as discussed. (iii) Infection control was not reported to the CQI meetings (May and June); (iv) Health and Safety was not consistently documented as reported to the CQI meetings where issues had been raised at the resident meetings.	Ensure that quality outcomes are reported to appropriate meetings for discussion and action 60 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 Moderate	Internal audits undertaken have an action plan documented, this is an improvement from the previous audit. However, the action plans documented did not always evidence they had been signed off as completed.	Where internal audits have been completed, an action plan has been documented where shortfalls have been identified. These have not always been signed off when completed. Examples include; audits for June and May.	Ensure that internal audit action plans are followed up and signed off when completed 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The service has a new training plan ready to implement. The training schedule for 2017 was not fully implemented and a training plan for 2018 (YTD) was unable to be evidenced. Staff appraisals were evident in all staff files reviewed. This is an improvement from the previous audit	The audit was unable to evidence at least eight hours of training for staff or a 2018 training schedule.	Ensure the scheduled training plan provided by the new quality system is implemented and all staff are provided with at least eight hours training that includes compulsory

				topics. 30 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>The service has a staffing policy in place. There is a RN rostered for each shift and the clinical manager is on-call. Not all shifts included a first aid trained staff member.</p>	<p>For the last two-week roster reviewed, there was no first aid trained staff member rostered across the night shifts or across four PM shifts</p>	<p>Ensure that there is a trained first aid person rostered for each shift</p> <p>90 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 consumer.</p>	PA Low	<p>All resident files included an up to date interRAI assessment and long-term care plan. The service is in the process of transferring to electronic care plans. Two of three recently admitted residents had their InterRAI and long-term care plan completed within set timeframes.</p>	<p>One hospital level resident's first interRAI and long-term care plan were not completed within timeframes.</p>	<p>Ensure that all new resident have interRAI assessments and long-term care plans completed within set timeframes</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the</p>	PA Moderate	<p>Interviews with staff, resident and family indicated that care needs were fully addressed, however charting/records in place to monitor interventions were not always completed.</p> <p>The service is in the process of implementing a new on- line wound</p>	<p>(i)The repositioning chart had not been consistently documented for one hospital level resident.</p> <p>(ii) Pain assessments have not been documented for one rest home resident, for whom pain was an identified issue.</p> <p>(iii) The required fluid chart had not been consistently documented for one rest home resident.</p>	<p>(i)-(iv) Ensure that monitoring charts are documented as instructed by the care plan.</p>

consumers' assessed needs, and desired outcomes.		management system, this system is not fully in place. Staff were aware of the care needs for the two wounds (one pressure injury, and a skin tear) but the documentation for these wounds was not clear.	(iv) Blood sugar monitoring was not consistently documented for a rest home resident. (v) Neurological observations had not been completed for two of four unwitnessed falls and any known head injury. (vi) Wound documentation on the on-line reporting system was not fully implemented, and therefore it was unclear if wounds had been re-dressed as per plan. (vii) The evaluation of the pressure injury did not include the size of the wound.	(v) Ensure that neuro observations are completed according to policy (vi) Ensure that the wound management processes document the wound management plan, on-going assessment, progress and evaluation 30 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Moderate	Activities were observed to be taking place on the day of audit. Residents and family agreed that the activities provided were acceptable. Not all resident had an individual activity plan or assessment.	(i) One rest home resident (YPD) had no activity assessment or plan. (ii) Two rest home residents and two hospital residents had an activity assessment but no activity plan in place.	Ensure that residents have an activity assessment and individualised activity plan documented. 60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with	PA Low	The maintenance person ensures that a system of environmental checks is in place and testing and tagging is documented for equipment. Hot water checks evidenced higher than 45	Hot water checks have been consistently documented, however during August and September the water temperatures were frequently documented as over 45 degrees with no remedial action documented as taken.	Ensure hot water temperatures are below 45 degrees in

legislation.		degrees in resident areas.		resident areas. 60 days
<p>Criterion 3.1.3</p> <p>The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.</p>	PA Low	<p>The service has policies and procedures documented for infection control. The infection control coordinator has a signed job description. There is no evidence that the infection control programme, infections training and staff practices for the previous year have been reviewed.</p>	<p>The infection control programme has not been reviewed annually.</p>	<p>Ensure the infection control programme is reviewed annually.</p> <p>60 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.