

Kohatu Resthome Limited - Kohatu Resthome

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 The DAA Group 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:	Kohatu Resthome Limited	
Premises audited:	Kohatu Resthome	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 26 February 2019	End date: 26 February 2019
Proposed changes to current services (if any):	None	
Total beds occupied across all premises included in the audit on the first day of the audit:	23	

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

Kohatu Rest Home provides residential care for up to 24 residents. The facility is operated by Kohatu Rest Home Limited and is privately owned.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management and staff.

Areas requiring improvement from the previous audit relating to the addition of a conservatory and civil defence supplies have been addressed. Areas requiring improvement from this audit relate to adverse events and residents' care planning.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if required.

The facility manager is responsible for the management of complaints. The complaints register is up to date. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Kohatu Rest Home Limited is the governing body and is responsible for the services provided. A business plan includes the scope, direction, goals, values and a mission statement. Quality and risk management systems are fully implemented. Systems are in place for monitoring the services provided including monthly reporting by the facility manager to the owner.

The facility is managed by an experienced manager/registered nurse who has been in the position for 10 years. The facility manager is also responsible for the clinical services in the facility.

There is an internal audit programme. Quality data is being collated, analysed and evidenced corrective action plans are developed and implemented. Staff and resident meetings are held on a regular basis.

There are policies and procedures on human resources management. Human resources processes are followed. An in-service education programme is provided and staff performance is monitored.

A documented rationale for determining staffing levels and skill mixes to provide safe service delivery is in place that is based on best practice. The facility manager is on call after hours.

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 low risk.
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Residents of Kohatu Rest Home have their needs assessed on admission and within the required timeframes. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files viewed were reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is provided by a diversional therapist and an activities officer and provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified overall satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is displayed. There have been no structural alterations since the previous audit.

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 restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard and identifies the use of enablers is voluntary and the least restrictive option to meet residents' need. There were no residents using restraints or enablers.

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.
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Aged care specific infection surveillance at Kohatu Rest Home is undertaken, data is analysed and trended. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

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	15	0	1	1	0	0
Criteria	0	40	0	1	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and families on admission. Complaints information and forms are available at the entrance to the facility.</p> <p>The complaints register evidenced no complaints have been received since the previous audit. The facility manager is responsible for complaints management and follow up. Staff interviewed demonstrated a good understanding of the complaint process and what actions are required.</p> <p>There have been no complaints investigated by the Health and Disability Commissioner (HDC) or other external agencies since the previous audit. The FM reported there has been one complaint made to the HDC since the previous audit. A letter from the HDC dated 27 August 2018 with associated documentation was reviewed. The letter to the facility and complainant states the HDC will not be investigating the complaint and that no action will be taken by the HDC.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Residents and families stated they are kept well informed about any changes to their own or their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is</p>

<p>with consumers and provide an environment conducive to effective communication.</p>		<p>supported by policies and procedures that meet the requirements of the Code of Rights.</p> <p>Residents and families interviewed stated they were kept well informed of activities happening at Kohatu Rest Home.</p> <p>Interpreter services can be accessed through the local DHB. The facility manager (FM) and staff reported this was rarely required due to all present residents being able to speak English. Multicultural staff with English as a second language are available to translate should this be 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>Kohatu Rest Home Limited is responsible for the services provided. A business management plan and a risk management plan were reviewed that included goals, purpose, objectives, mission statement and values. The owner and the FM stated the owner visits the facility at least weekly and meets with the FM. Monthly management meetings with the owner are held on site and minutes of the meetings were reviewed and showed a wide range of topics are reported, including, but not limited to complaints, corrective actions, audits, incident/accidents, training, performance appraisals, staffing, health and safety.</p> <p>The facility is managed by a facility manager (FM) who is a registered nurse with extensive aged care experience and has been in this position since November 2008. The FM keeps up to date by attending the aged care forums provided by the local DHB. Review of the programmes for 2018 and 2019 evidenced a wide range of appropriate subjects are provided. The facility manager is supported by an assistant manager ('2IC') who has been in the position for four years, as well as the owner.</p> <p>The service's philosophy is in an understandable form and is available to residents and their family/representative or other services involved in referring residents to the service.</p> <p>On the day of this audit there were 23 residents assessed as requiring rest home level care, including one respite resident. There is one boarder who resides in a sleep-out. Kohatu has contracts with the DHB for 'Residential Respite Services' (including day care), 'Aged Related Residential Care Services' and a contract with the local hospice.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management</p>	<p>FA</p>	<p>A business risk management plan and quality indicators 2019/2020 guides the quality programme and includes goals and objectives. Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed. There was documented evidence quality improvement data is being collected, collated, analysed and reported and graphs are generated. Quality improvement data included adverse events, internal audits, meeting minutes, satisfaction surveys, infection control surveillance and health and safety. Corrective action plans are being developed, implemented, monitored and signed off as being completed. (See corrective action required 1.2.4.3) Monthly staff meetings included quality, health and safety, restraint and</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>infection prevention and control. Meeting minutes are available for staff to read and sign off.</p> <p>Policies and procedures reviewed are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and a document control policy. Staff confirmed they are advised of updated policies and that they provide appropriate guidance for the service delivery.</p> <p>A Health and Safety Manual is available that includes relevant policies and procedures. Actual and potential risks are identified associated with human resources management, legislative compliance, contractual risks and clinical risk. The hazard register identifies hazards and showed the actions put in place to isolate or eliminate risks. New hazards are communicated to staff and residents as appropriate. The 2IC is the health and safety coordinator and is responsible for hazards. The 2IC demonstrated an understanding of health and safety requirements. Staff confirmed they understood and implemented documented hazard identification processes.</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>PA Moderate</p>	<p>Incident /accident forms are being completed by care staff, apart from recording neurological observations for residents who have experienced a fall. A form had not been completed for a resident who has a pressure injury. The 2IC collates the data monthly, completes analysis and identifies any trends and generates graphs. Although corrective actions are implemented, they are not documented in the resident's care plan. Not all incident/accident forms have been signed off and dated. Some forms reviewed by the 2IC have been signed using their first name only. There is currently no clinical overview by the FM/RN.</p> <p>Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM advised there have been no essential notifications made to the Ministry of Health or any other external agency since the previous audit. A Section 31 was completed and sent to HealthCERT during the audit as a result of Police involvement relating to an event at the facility a week ago, concerning a visitor and a day care resident.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and</p>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files reviewed included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>The education programme is the responsibility of the FM. In-service education is provided for staff in several ways including monthly education sessions prior to the staff meetings, 'tool box' talks at handover, on-line learning and specific topics relating to resident's health status. The local DHB also provides education and forums for facility managers. Educators also come to the facility to provide education. Individual records of</p>

<p>meet the requirements of legislation.</p>		<p>education including competencies are held on staff files and in an education folder. Attendance records are maintained. The FM is interRAI trained and has a current competency.</p> <p>A New Zealand Qualification Authority education programme is available to staff. The FM is the assessor for the facility. Staff are encouraged to complete the programme and some staff have attained levels 2 and 3.</p> <p>An orientation/induction programme is in place and all new staff are required to complete this prior to their commencing caring for residents independently. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.</p> <p>Staff performance appraisals were current. Annual practising certificates were current for the FM and contractors who require them to practice. Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. The FM reported they review the rosters weekly and consider dependency levels of residents and the physical environment. The FM/RN works full time and the 2IC works three days a week. There is always a senior caregiver rostered on each shift. Three caregivers work on the morning shift with finishing times staggered. One caregiver has a dual role and is also the cleaner. Three caregivers work the afternoon shift. One caregiver works on the night shift with one on call. All care staff are responsible for the management of laundry as part of their role.</p> <p>The FM is on-call after hours. Care staff interviewed reported there are adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided.</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</p>	<p>FA</p>	<p>The medication management policy at Kohatu was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These</p>

<p>guidelines.</p>		<p>medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the electronic medicine chart.</p> <p>There were no residents who were self-administering medications at Kohatu at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and facility manager (FM) and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</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>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian - 24 October 2018. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and was registered with the New Plymouth District Council on the 29 March 2018.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available, including the use of coloured plates, to identify residents requiring nutritional monitoring.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys</p>

		and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were enough staff on duty in the dining rooms at meal times to ensure assistance is available to residents as needed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Except for that mentioned in criterion 1.3.3.4, documentation, observations and interviews verified the care provided to residents at Kohatu was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Documentation by the GP verified that medical input was sought in a timely manner and that medical orders were followed. Care staff confirmed that care was provided as verbally requested and in documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities programme is provided by a diversional therapist and an activities officer, who share the role four days a week. On Monday, activities are provided by community volunteers and local entertainers. A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements (Map of Life). The resident's activity needs are evaluated regularly, however the activities plan is not updated to reflect residents' change in needs (refer criterion 1.3.3.4). The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Examples included visiting entertainers, quiz sessions and daily news updates, attendance at community events, visits to other rest homes, bingo, skittles and church services. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their needs.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Except for that referred to in criterion

comprehensive and timely manner.		1.3.3.4, where progress is different from expected, the service responds by initiating changes to the plan of care. Examples were sighted of short-term care plans being reviewed for infections, pain, weight loss and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed that expires on the 7 March 2019. The FM advised the renewal process has been instigated. There have been no structural alterations since the previous audit. A proactive and reactive maintenance programme ensures that buildings, plant and equipment are maintained to an adequate standard. Documentation, interviews and observation confirmed this. The testing and tagging of equipment and calibration of bio medical equipment was current. Recordings of hot water temperatures showed temperatures at resident outlets are consistently 45 degrees Celsius or below. The findings from the previous audit have been addressed. The extension built in July 2016 has been inspected by the local authority and a code compliance certificate was sighted. Handrails have been installed on either side of the ramp that extends from the external conservatory door to the outside.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Staff have received education in emergency and security management and staff interviewed and documentation confirmed this. Fire evacuation drills are completed six-monthly. A civil defence plan is in place. Adequate supplies of food, water, blankets, cell phones and a gas BBQ were sighted in the event of a civil defence emergency. Battery powered emergency lighting is provided. The findings from the previous audit have been addressed. The contents of the civil defence kit meet the recommended items needed in an emergency. Documentation evidenced the contents is checked six monthly and was last checked in October 2018. A letter from the NZ Fire service dated 26 October 2017 evidenced that as a result of building an extension on to the existing building, there was no change to the fire evacuation scheme required, which remains approved from the 31 March 1995.
Standard 3.5: Surveillance Surveillance for infection is carried out in	FA	Surveillance of infections at Kohatu is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required

<p>accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control nurse and FM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's infection database. Graphs are produced that identify trends for the current year, and comparisons against previous years.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy has a section on enablers that includes a definition, assessment and evaluation and complies with the requirements of the standard. The restraint coordinator is the FM/RN. There were no residents using either a restraint or an enabler at the time of audit. The FM advised restraint has not been used since they started in the role, 10 years ago. Staff interviewed demonstrated knowledge of the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.</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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify</p>	<p>PA Moderate</p>	<p>The majority of incident/accident forms are completed fully, however, there was evidence that this is not consistent. In the event of a resident falling, neurological observations are not taken and recorded. The FM/RN does not review the completed incident/accident forms. This role is currently undertaken by the 2IC who is not an RN. A form was not completed for one resident who has developed a pressure injury. Not all forms were signed and dated. Some were signed with the 2IC's first name only.</p> <p>Although the incident/accident forms are used to produce quality data and identify corrective actions that are implemented, corrective actions are not being entered into the resident's care plans.</p> <p>Staff were provided with training during the audit relating to fully completing incident/accident forms.</p>	<p>(i) Neurological observations are not being taken and recorded. (ii) Not all incident/accident forms are signed appropriately. Some are not signed and dated. (iii) An incident/accident form is not always completed following an adverse event. (iv) Completed incident/accident forms are not currently reviewed by the FM/RN. (v) Corrective actions are not being entered into the resident's care plan.</p>	<p>Provide evidence that: (i) neurological observations are taken and recorded on incident/accident forms and all forms are signed and dated following review; (ii) an incident/accident form is completed following all adverse events experienced by residents; (iii) the FM/RN takes responsibility for review of all incident/accidents received especially where clinical input is indicated; (iv) any corrective actions are entered into the resident's care plan.</p>

and manage risk.				30 days
<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 Low	<p>Five of seven files reviewed did not have documentation in the care plan that described fully the care the resident required to meet all their needs. Evaluations were undertaken every six months. Two of the five files documented the required changes to care in the evaluations, however the plan of care was not updated to include these changes.</p> <p>A resident who had recently developed a pressure injury, had no documentation in the care plan identifying the resident's skin was no longer intact. An incident recording the presence of a pressure injury was not documented (refer criterion 1.2.4.3). A wound management plan, including wound assessment and monitoring was sighted. A previous pressure injury and strategies to minimise the risk were not documented, nor was there documentation to plan the resident's care during recent incidents of respiratory distress and a chest infection. The resident's care plan did not reflect the resident's increased dependency and need level. A request for reassessment of the resident was made on the day of audit. If reassessed as requiring hospital level care, the facility planned to apply for an exemption, so the resident could remain at Kohatu.</p> <p>Two other files reviewed made no reference to recent events of unwitnessed falls and the required management of possible head injuries. Incident forms for these incidents were sighted, however the need for neurological assessment was not included (refer 1.2.4.3).</p> <p>Residents' weights were recorded on a regular basis, however these were recorded in a separate book and not updated in seven of the seven care plans reviewed.</p> <p>Recreation plans in five of the seven files reviewed were not updated to reflect changes in the resident's recreational needs.</p>	Care plans do not consistently describe fully the residents' required needs to ensure continuity of service delivery.	<p>Provide evidence care plans describe fully the care the resident requires to ensure continuity of care can be provided.</p> <p>180 days</p>

		<p>These findings were verified by observations and interviews with the facility manager, the second in-charge staff member and the recreation officer.</p> <p>Evidence was sighted through documentation in progress notes or via additional reporting, to verify all residents received the care required, despite the documentation being absent in the care plan. Interviews with care staff verified care was delivered in line with residents' current needs, however staff acknowledged this was not documented in the care plan.</p>		
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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.