# Norfolk Court Home & Hospital - Norfolk Court Rest Home

## 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 Q-Audit 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Norfolk Court Home & Hospital Limited

**Premises audited:** Norfolk Court Rest Home

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

**Dates of audit:** Start date: 28 August 2019 End date: 28 August 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:** 47

# 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 |
|  | 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

Norfolk Court can provide rest home, hospital and dementia care for up to 63 residents. There have been some minor changes since the last audit. The facility has had a number of improvements made regarding refurbishments and maintenance and a new clinical nurse coordinator role has been developed.

This unannounced surveillance audit was conducted against a sub set of the health and disability standards and the organisations contract with the district health board. The audit included samples of staff, residents, management and administration records. Residents, family members, a general practitioner and staff were interviewed. Support interventions, staff meetings, meal services and activities were observed. The managing director was present throughout the audit. Previously identified areas of improvement were followed up.

There are two areas which now require further improvements. These include the timeframes for completing assessments and care plan reviews and the management of controlled drugs. Both these areas were identified during the last audit and are yet to be fully addressed. No additional areas of improvement were identified.

## 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. |

Management and staff communicate in an open manner and residents and family members are kept up-to-date. Residents have access to interpreter services if required. Open disclosure is evident in event records sampled. The rights of residents or their legal representatives to make a consumer complaint is understood, respected, and upheld. An up-to-date complaints register is maintained.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

There have been no changes in governance since the last audit. Organisational performance is monitored by the directors. The required policies, procedures are documented and accessible. The quality and risk management system has been maintained and continues to generate improvements in practice and service delivery. The organisation implements an internal monitoring programme. Corrective actions are developed where a short fall is identified. Risks are identified and managed accordingly. The adverse event reporting system provides comparable benchmarking data.

The human resource management system has been maintained and is consistent with accepted practice. There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery for all residents.

Individual resident records are maintained. Entries into records meet the requirements of this standard.

## 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. |

The registered nurses (RNs) are responsible for completing nursing assessments, care planning and evaluations. InterRAI trained nurses complete the interRAI assessments.

The planned activities provided are appropriate to meet the needs, age, culture, and setting of the service. The activities reflect ordinary patterns of life and include involvement of other representatives and community groups.

The service uses pre-packaged medication and a paper-based medicine management system. Medication is administered by staff with current medication competencies. Medication reviews are completed by the general practitioners (GPs) as required.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals. Snacks are available for residents if needed throughout the night. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. There is a food control plan in place.

## 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. |

There have been no changes to the facility since the last 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. |

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. The use of restraint is minimised. Records sampled demonstrate safe restraint and enabler use. All staff receive the required training, including the management of challenging behaviour. Environmental restraint is in place for residents in the secure dementia unit in the form of coded locked doors however visitors come and go as they please.

## 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. |

Infection data is collated monthly, analysed and reported. The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of the surveillance are acted upon, evaluated and reported.

## 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 | 0 | 2 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 0 | 2 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure meets the requirements of consumer legislation. Residents and family members interviewed confirmed access to the complaint’s procedure and stated they would feel comfortable making a complaint if required. The complaint forms are readily available, as are contact details for the national advocacy service. The complaints register has been maintained. This includes the nature of the complaint, actions and outcomes. There have been four complaints added to the register since the last audit. Two of these were found to be partially substantiated with the required remedial actions implemented. The managing director continues to acknowledge each complaint in writing and includes Norfolk Courts responsibilities. Apology letters were sighted, in the event the complaint has been substantiated. There was also evidence of advocacy involvement in complaint records sampled and family notifications were made as required. The managing director reported that there have been no complaints made to external agencies since the last audit. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service has access to interpreting services for the residents if this is required. These services can be provided through the DHB. Policies and procedures are in place if interpreter services are required. There were no residents requiring interpreter services at the time of the audit. There was evidence of open disclosure in the adverse event records sampled. Residents and family members interviewed reported they are informed of any events or concerns and that management was easily accessible and responsive to feedback. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Ownership and management of Norfolk Court has not changed since the last audit. Both owners/directors are on site daily and maintain up to date with current trends in the aged care sector through attendances at regional provider meetings, membership with the aged care association and quarterly benchmarking meetings with other providers. The mission statement for the organisation has remained the same. The managing director is currently drafting the 2019-2020 business plan which aligns with the financial year. The draft was sighted and demonstrated consideration regarding the strategic direction for the organisation. The directors are supported by the clinical team. Organisational performance is closely monitored. Monthly management meetings are conducted with representation from across the organisation and chaired by the managing director. These meetings are used to discuss business performance, facility management and organisational and clinical risk. The managing director has recently developed a quality framework, which demonstrates an ongoing commitment to improvement processes.The rest home is certified to provide 63 residential beds. This includes 35 dual purpose beds (for residents requiring either rest home or hospital level care), seven designated rest home level beds and a 15-bed secure dementia unit (the Haven). A number of the dual purpose and rest home rooms can operate as double rooms if required. There were 47 residents on the day of the audit. This included 15 residents in the Haven, 17 residents occupying hospital level beds and 15 residents occupying rest home beds. Norfolk Court can also provide respite services, long term and short term stays if required. There is one resident under the residential respited contract at the time of the audit. There were no residents under the age of 65 years. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The documented quality and risk management system remains compliant to requirements of this standard and the contract with the DHB. The required policies and procedures are documented and accessible. There is a system for developing, amending and approving new documents. Documents are controlled and obsolete documents are removed from circulation. A range of quality activities are completed. All quality related data is collated and trends identified. Resident satisfaction surveys are conducted and there is sufficient evidence that feedback regarding the results of surveys, and any related corrective actions, have been shared with the residents during residents’ meetings. The managing director maintains a comprehensive schedule of all monitoring and performance requirements. This includes the implementation of routine, and extraordinary, internal audits. The organisation is also registered with a benchmarking group where clinical indicators are set and measured on a quarterly basis. This includes eight providers in the area with benchmarking data closely linked with clinical outcomes and adverse events. There is a routine internal audit programme. In addition, a comprehensive internal audit was completed by the managing director in April 2019. This included resident files and safe clinical management and compared similar data from 2018 with areas of improvement and areas not yet achieved clearly identified. There is evidence that improvements are made in an ongoing manner. The organisation has maintained a clinical quality initiative register since 2017 which provides evidence of all the ongoing changes, risk and improvements to the system. This also provides evidence of corrective actions following the identification of any breach in process. Organisational risk is documented. A review of organisational risks was completed by the managing director in May 2019. The review identified all current organisational risks and strategies. A significant identified risk to the organisation remains the recruitment and retention of registered nurses. There is evidence of risk monitoring in meetings minutes sampled. There is a health and safety programme which aligns with current legislation. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | There is a documented process for the management of adverse events. All staff have access to the adverse event reporting process. Clinically related events are forwarded to the clinical nurse coordinator with all others forwarded to the managing director. Events are monitored by type, time and location. This provides sufficient data to identify trends, develop targeted corrective actions and benchmark against other providers in the sector. Data on all adverse is reported at management meetings. A full analysis of all adverse events was sighted. Results are published and displayed to staff.Records of adverse events were sampled. There was evidence of the required immediate actions, assessment, observations and preventative actions. Essential notifications were made as required. Serious assessment codes (SAC) are used. There is evidence that the police, Ministry of Health, DHB, general practitioner and family are notified as required. Improvements have been made to the open disclosure process in 2019 to ensure that all notifications to residents/family are made as required. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are written policies and procedures in relation to human resource management which comply with current good employment practice. Staff files sampled confirmed that the skills and knowledge required for each position is documented in job descriptions. Job descriptions outline accountability, responsibilities and authority. There is a process for recruitment screening and the validation of professional qualifications for both employed and external health professionals. Staff receive an orientation to the facility and to their respective role. The orientation programme includes the essential components of service delivery, including emergency procedures. A buddy programme is implemented and records of buddy training are maintained.Care givers are required to commence the national certificate in working in aged care within six months of commencement. Staff working in the dementia unit have either commenced, or have completed the required dementia related qualifications. All registered nurses are required to have a medication competency, as are the care givers who work in the dementia unit. The required competencies were sighted. All staff have a current first aid certificate. There is a planned programme of on-going education. The programme has been maintained and resources are well documented. A training planner is developed annually and meets the contract requirements in terms of topics to be covered and hours to be maintained. The previously identified area of improvement regarding low attendance at mandatory training was addressed. The organisation now conducts quarterly one-day compliance training. This is a one-day training which includes all the required mandatory topics. Records of training days sampled confirmed an improvement in attendance. Staff performance is monitored. All staff have an annual performance appraisal. There is a process for determining who is due for their appraisals and records are maintained regarding attendance. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing is a combination of management, registered nurses, care givers, administration and housekeeping staff (including maintenance). The largest group of employees is care giver staff with a total of 30. The organisation has had a high turnover of registered nurses over the past two years resulting in difficulties completing assessment and care plan review requirements (refer standard 1.3.3). The managing director has identified these concerns to the both the Ministry of Health and the DHB. There are currently five registered nurses, with three trained in interRAI, one of whom is the clinical nurse manager who is currently on long leave. The clinical nurse coordinator is now completing the nurse manager’s tasks. There are currently two nursing vacancies which will be filled once the new nurses have completed their competency assessment programmes. The staffing allocation policy and procedure reflects contract requirements. Rosters were sampled and confirmed that the current staffing numbers meet contractual requirements. There are two care givers rostered in the Haven during morning and afternoon shifts, and one during the night. There are five staff on the roster in the rest home and hospital during the morning shift, four rostered in the afternoon and two during the night. There is a one registered nurse per shift plus the clinical nurse coordinator being rostered accordingly to cover both clinical and management duties. The registered nurses have also been allocated four shifts per week to address care planning, updating and reviewing care plans. A registered nurse is also rostered a shift to attend the weekly medical clinic. There is evidence that all unplanned absences are covered.  |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Records of current and previous residents are securely maintained. Residents' demographic information is documented on entry. The admission assessment includes verification and documentation of individual resident information. The sample of residents’ records indicates that they include reports from all health professionals. Records are integrated in the one file. Entries are legible, dated, signed and designated. Staff are required to write a progress notes during each shift, with additional entries if there has been a change or specific event. Progress notes were sampled and confirmed routine entries per shift. The date and designation of the writer were documented. The previously identified area of improvement regarding time of entry in resident records has been addressed.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management using paper-based system was observed on the day of audit. The staff observed administering medicines 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 have completed a medication competency assessment. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Medication reconciliation is conducted by the RNs. All medications sighted were within current use by dates. The records of temperature monitoring for the medicine fridge were sighted. No vaccines are kept onsite. Clinical pharmacist input is sought when required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for ‘as required’ (PRN) medicines are met. The required three-monthly medication reviews were consistently recorded on the medicine charts. Standing orders are used, are current and comply with guidelines.There was one resident self-administering nasal spray at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.An improvement is required in ensuring that weekly and six-monthly controlled drugs stock checks are consistently completed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food service is provided on site 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 within the last two years. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan. Food temperatures, including for high risk items, are monitored appropriately and recorded consistently. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. Cleaning schedules are in place and completed regularly. The kitchen was clean on the day of the audit.A nutritional assessment is undertaken for each resident on admission to the service 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. Residents in the secure dementia unit always have access to food and fluids to meet their nutritional needs 24 hourly. Special equipment, to meet resident’s nutritional needs, is available.On the day on the audit, residents were given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Evidence of resident satisfaction with meals was verified by residents and family in interviews conducted.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified that care provided to residents met assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Interventions sighted in care plans sampled were consistent with good practice. Progress notes are completed every shift by the caregivers and weekly or when required by the clinical nurse coordinator. A range of equipment and resources were available, suited to the level of care provided and in accordance with the residents’ needs. Staff confirmed they have access to the supplies and products they needed. Monthly observations are completed and are up to date. Interviewed family members and residents reported satisfaction with the services provided. |
| Standard 1.3.7: Planned ActivitiesWhere 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 coordinator completes the activities assessment for all residents on admission with the help of the residents and/or family where appropriate. A preadmission form that provides information on past and present hobbies is given to prospective residents at inquiry stage and they bring it back completed at time of admission. A social assessment and history are undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Individual activities plans were sighted in sampled files. There is a monthly and weekly activities programme completed by the activity coordinator. The weekly activities programme is posted on the notice board for residents’ easy access. Daily activity plans are written on the white board each day There are group activities and individual activities for rest home and hospital level residents. Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living with dementia. Activities are offered at times when residents are most physically active and/or restless. Twenty-four-hour care plans were in place for residents in the dementia unit. There are also combined activities for rest home, hospital and dementia level residents when external entertainers are performing. Residents have access to community events and community outings.There is an activities participation register that is completed daily and activity plans are evaluated six-monthly by the activity coordinator. Records were sighted in sampled files. Residents were observed participating in various activities on the day of the audit.Residents and family members are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys as confirmed by meeting minutes sighted. Interviewed residents reported satisfaction with the activities programme. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes by caregivers. If any change is noted, it is reported to the RN. There is a process for evaluating the long-term care plans and interRAI assessments six-monthly, however the timeframes were not consistently completed (refer 1.3.3.3).Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for urinary infections and wounds. Short term care plans are evaluated regularly and closed off when the condition has resolved, or issues are transferred to long term care plan if indicated. Residents and family members interviewed confirmed 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 | There have been no changes to the facility since the last audit. The current building warrant of fitness and approved evacuation plan was sighted. Trail evacuations are completed every six months as required. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection surveillance programme remains appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. All results of surveillance and specific recommendations are to assist in achieving infection reduction and prevention outcomes. These are acted upon, evaluated and reported to relevant personnel and management in a timely manner. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. Data regarding all types and categories of audits is used for benchmarking purposes and communicated across the organisation. There was also evidence that the organisation researches and follows up on any concerns regarding best practice for diagnosing and treating infections. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The organisation aims to minimise the use of restraint. A current restraint register was sighted. All staff receive training regarding restraint, enablers and challenging behaviours. Risk minimisation is documented in the care plans of the residents and restraint/enabler use is evaluated regularly. The family and residents are fully informed about the restraint process. All restraints are approved, assessed and used safely. At the time of the audit there were seven residents using an approved restraint The Haven provides a secure environment where residents can safely wander within the unit and outdoor areas.  |

# 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 1.3.12.6Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Controlled drugs are administered as per controlled drugs administration guidelines. Documentation of administered controlled drugs was sighted in the controlled drugs register, medication signing charts and residents’ progress notes. The controlled drugs were being reconciled weekly when they are received from the pharmacy, but the required weekly and six-monthly stock checks were not completed consistently. The previous audit identified the same area for improvement, and it was closed off by the DHB in March 2019 as reported by the manager. | Weekly and six-monthly stock checks were not completed consistently in the controlled drugs register. | Ensure that weekly and six-monthly controlled drugs stock checks are completed consistently30 days |
| Criterion 1.3.3.1Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function. | PA Moderate | The previous audit identified that timeframes of completion of initial interRAI assessments, six-monthly evaluations and six-monthly care plan evaluations were being monitored by the local DHB. This audit identified that the required timeframes for the same areas are still not met. There are three interRAI trained nurses and there is a system in place to address the identified interRAI assessments and care plan evaluation requirements. The risk rating has not been raised in consideration of the ongoing work and monitoring which is being conducted to address the situation.  | The majority of interRAI assessments were overdue for six monthly review and one new admission did not have interRAI assessment completed within three weeks of admission. | Ensure that interRAI assessments and care plan evaluations are completed within the timeframes required.60 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

|  |
| --- |
| No data to display |

End of the report.