The Willows Home and Hospital Limited - The Willows Home and Hospital

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:	The Willows Home and Hospital Limited
Premises audited:	The Willows Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 September 2018 End date: 11 September 2018

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: 26

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

The Willows Home and Hospital provides rest home and hospital level care for up to 28 residents. The service is operated privately, and the owner/director is the manager. She is supported by an administrator/maintenance manager and a clinical nurse manager who is a registered nurse. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against 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, family members, management, staff, and a general practitioner.

This audit identified eight areas requiring improvements relating to corrective action documentation, adverse event documentation, human resources management, short term care planning, activities, medicine management, nutrition and kitchen cleaning. Improvements have been made to complaints management, staff medication competencies, electrical safety checks, the kitchen environment and the annual review of the infection control programme. The two areas not addressed from the previous audit relate to medication management and corrective action 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.

The service promotes open communication between staff, residents and families which was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints resolved promptly and effectively.

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 low risk.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. The owner/director works full time at the facility and monitors the services provided. She has owned and operated the business for the past 19 years. She is supported by a clinical nurse manager who holds a current nursing annual practising certificate who has also worked at the facility for 19 years and has held her current role for 15 years.

The quality and risk management system includes collection and analysis of quality improvement data and identifies trends. Staff are kept informed of findings. Staff are involved in making improvements, and feedback is sought from residents and families.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is undertaken by the management team. A systematic approach to identify and deliver ongoing training supports service delivery. Staffing levels and skill mix meet the changing needs of residents.

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 service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. All residents have interRAI assessments completed and individualised care plans related to this programme. All care plans are evaluated at least six-monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu. Residents' nutritional requirements are met.

Medication policy identifies current best practice for medication management. Staff who administer medication have completed a medication competency in the last 12 months.

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 is a current building warrant of fitness. Equipment and electrical safety checks have been undertaken and the kitchen bench can be cleaned to meet infection control standards.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. One enabler was in use at the time of audit. No restraints were in use. Procedures include an appropriate assessment, approval and monitoring process should restraint be required. An annual restraint quality review is documented by the restraint committee which includes the GP. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

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	10	0	6	0	1	0
Criteria	0	32	0	7	0	1	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The owner/director and the clinical nurse manager are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The complaints register reviewed is up to date and showed that eight complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. One example relates to meals being cold when served. The follow up included staff education about how to prevent this. The resident who made the complaint was asked after a three week period if they were happy with their meal temperatures and it was confirmed that they were. Documentation of all complaints and follow-up was an area identified for improvement in the previous audit and has been fully addressed by the service. There have been no complaints received from outside sources since the previous audit.
Standard 1.1.9: Communication Service providers communicate	FA	Residents and family members stated they were kept well informed about any changes to their/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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. The informed consent

effectively with consumers and provide an environment conducive to effective communication.		document is provided in nine different languages. Staff knew how to access interpreter services. At the time of audit four residents did not understand English and are supported by staff who speak the same language, family and the use of the interpreting service as required. There was one resident that was identified with a significant sensory impairment and resources and equipment were observed to be in place, for example, support from the Blind Foundation, talking books/watch and support from staff regrading mobility and daily activities of living. The resident and family newsletter sighted, which is developed three times a year, provides information and reminders, for example, how to raise a concerns/complaints, preventing of infection and good hand hygiene, the invitation of family to be a part of resident's care planning and further information in regard to the importance of residents privacy and their right to decide.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. As the owner/director works full time at the facility she is aware of all performance results including financial performance, quality data results, complaints, emerging risks and issues. The clinical services are managed by a registered nurse who holds relevant qualifications and has been in the role for 15 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The owner/director and clinical nurse manager confirmed their knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing in-service education, attendance at an age care regulatory group and on-line education. The service holds contracts with Auckland District Health Board (ADHB) and the Ministry of Health (MoH) for respite care, carer support, rest home and hospital long term support and ACC. On the day of audit 26 residents were receiving care under the following contracts: - two ACC residents under the Residential Support Service contract - two residents under the Long-Term Support - hospital level care - two under the Long-Term Support – rest home level care and - 19 under Age Related Residential Care - being 13 hospital and six rest home level care. - One resident who originally entered the facility under an ADHB Primary Options for Acute Care (POAC) contract which had expired was waiting to be reassessed as rest home level care. The geriatrician undertook the reassessment on the day of audit.
Standard 1.2.3:	PA Low	The organisation has a planned quality and risk system identified in policy and procedures. This includes

Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections, wounds and pressure injuries. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective actions. Corrective actions are not always documented but staff stated during interview that any corrective actions required are verbally discussed at daily handover and implementation is monitored by the management team. Resident and family satisfaction surveys are completed annually. The most recent survey (March 2018) for which only three completed surveys were returned, showed that a negative comment related to activity outings was not followed up. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are provided by an off-site company and personalised to the service. They are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The owner/director and administrator/maintenance manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There is a risk register in place which covers all aspects of service delivery.
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.	PA Low	Staff document adverse and near miss events on an accident/incident form. A sample of accident/incident forms reviewed showed these were completed to a level to show initial actions taken such as skin tear dressed, family notification and if the GP was informed. Data results are shared with staff at each meeting and any corrective actions required are discussed at the daily shift handover. The corrective actions reviewed for incidents and accidents were documented in the residents' notes with outcomes shown. The incident and accident forms did not identify fully what ongoing corrective actions were to be taken such as putting a dressing plan in place or the need to take neurological observations. This was discussed with management at the time of audit and they amended the accident/incident forms so that they can clearly show all corrective actions taken and the outcomes to measure the success of the actions. The service will continue to also enter this information in the residents' clinical notes. Adverse event data is collated and analysed monthly, but no documented evidence was available to show that information gathered on incidents and accidents is used to improve services. The owner/director described essential notification reporting requirements, including for pressure injuries. They advised there has been one notifications of a grade three pressure injury made to the Ministry of Health on the 14 August 2018. There have been no police investigations, coroner's inquests, issues-based audits and any other notifications since the previous audit.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed identified that the organisation's policies are not being consistently implemented related to staff education records. There is no documented system in place to show when staff appraisals are due and annual appraisals are not all up to date to meet contractual requirements. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff undertake approved (NZQA) on-line education. There are three trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance updates for interRAI.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. This was confirmed during staff interviews and by the owner/director. The clinical nurse manager and owner/director are on call, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage. Healthcare assistants undertake cleaning and laundry as part of their daily duties and this is identified in their job descriptions. A cook works 7am to 2pm seven days a week. The activities coordinator works three days a week 10am to 3pm and healthcare assistants undertake the activities as described in the activities calendar on the other days.
Standard 1.3.12: Medicine	PA High	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.

Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.		A system for medicine management using a paper-based system was observed on the day of audit. The staff observed on the day of audit demonstrated safe medication practice. All staff who administer medicines have undertaken an annual medication competency. Most medications are supplied to the facility in a pre-packaged format from a contracted pharmacy which is checked by a registered nurse on arrival. All medications sighted were within current use by dates. Clinical pharmacist input is evident. Controlled drugs are stored securely and checked by two staff for accuracy when administering. The previous audit identified an area for improvement to ensure that care staff who check medications are assessed as competent to perform their role. The corrective action is now addressed, and records were available to demonstrate this. The controlled drug register provided evidence of six-monthly stock checks and accurate entries. The previous audit identified an area for improvement to ensure that all the controlled drug checks are recorded in the controlled drug register weekly. This has been partially addressed, but further improvements are required. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. With the exception of one resident the prescriber's signature and date of the commencement and discontinuation of medicines were sighted as was and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine charts. Standing orders are not used. There were no residents who were self-administering medications at the time of audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	PA Low	The food service is provided on site by one of two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns. The menu has not been reviewed in the last two years by a dietitian. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. At time of audit the kitchen did not have a cleaning schedule or signing sheet. The service has a food safety plan registration issued by the Ministry for Primary Industries which expires 20 June 2019. 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. 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. Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring

		assistance had this provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care; however, neurological observations are not being measured for unwitnessed falls (see criterion 1.2.4.3). Care plans were identified for wounds, but short-term care plans were not evident for infections. There is one house doctor. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation and discussions at handover. A range of equipment and resources was available, suited to the levels 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.	PA Low	The activities programme is provided by an activities co-ordinator and supports the residents Tuesdays, Wednesdays and Thursdays from 10.00 am – 3.00 pm. There are also activities planned and provided to residents on Sunday. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements; however, not all residents files sighted had this initial social assessment and history undertaken. The resident's activity needs are evaluated weekly and as part of the formal six-monthly care plan review. Several residents maintain their independence and regular participation in the community. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme to help formulate an activities programme that is meaningful to the residents and this occurs through daily residents' discussions and satisfaction surveys. Residents interviewed confirmed they find the programme interactive and stimulating.
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. 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. Where progress is different from expected, the service responds by initiating changes to the plan of care and document in the progress notes. Examples of wound care plans being reviewed and progress evaluated as clinically indicated were sighted. Short term care plans were not always sighted for infections (see criterion 1.3.6.1). When necessary, and for unresolved problems, long term care plans are added to and updated. 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 (expiry date 09 February 2019) is publicly displayed. The service has adequate biomedical equipment which was checked in July 2018. They also have bariatric beds, hoists, commodes and wheelchairs. The beds are progressively being updated to remote control electronic hospital level care beds which staff state is a great improvement. The issues identified in the previous audit have been fully addressed by the service and electrical safety checks are completed. The kitchen bench has been replaced with a stainless steel bench and can be cleaned to meet infection control standards.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service implements an infection prevention and control (IPC) programme to minimises the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from gerontology nurse specialist as required. The previous audit identified an area for improvement to ensure that the infection control programme and manual are reviewed annually. The corrective action is now addressed with records available to demonstrate that this last occurred in January 2018.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified	FA	Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/owner manager reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed. 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 regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the IPC co-ordinator and reported to all staff. The facility has had a total of 28 infections from March 2018 to August 2018 with a total of 37 infections noted in

in the infection control programme.		2017. Three residents have been identified with seven of those 28 infections due to co-morbidities. The residents' files reviewed long-term care planning to reduce and minimise the risk of infection, but residents files did not show evidence of short term care plans (see criterion 1.3.6.1). Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities. On the day of audit, no residents were using restraints and one resident was using bedside rails as an enabler. The resident confirmed during interview that they had requested the bedside rails so they can remain independent whilst in bed. These enablers, which were the least restrictive and used voluntarily at the resident's request. The resident had a signed consent form for the enabler. Restraint would only be used as a last resort when all alternatives have been explored and the facility is aiming to remain restraint free. This was evident on review of the restraint approval group minutes, files reviewed, and from staff interviews.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Corrective actions were sighted for environmental issues which required improvement with outcomes identified. Complaints management corrective actions are clearly shown. However, incident and accident corrective actions are not always completed. For example, in relation to skin tears it is stated that a dressing has been applied but it is not identified if a wound care plan was put in place. The review of resident files identified that wound care plans are put in place as required. (Refer comments in criteria 1.2.4.3 and 1.3.6.1). The resident satisfaction survey had a negative comment related to the type and number of outings. No documented follow-up could be found related to this and the resident who made the comment is no longer at the facility. No residents interviewed on the day of audit made any negative comments related to activity outings. This was an area identified for improvement in the previous audit and whilst the service has made some improvements in this area, not all corrective actions are documented.	No corrective actions are documented related to resident satisfaction survey results. Not all completed corrective actions taken related to the management of skin tears are documented.	Provide evidence that all corrective plans are documented. 180 days

Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Low	Adverse events are recorded on incident and accident forms. The form used did not identify if neurological observations were required only standard recordings such as blood pressure and pulse. Following discussion with management the form was updated to identify the need for further recordings for unwitnessed falls. Incident and accident information is documented in the individual residents' clinical notes but no documented evidence was sighted to show how the findings were being used as an opportunity to improve services. Refer comments in criterion 1.2.3.8.	No documentation sighted confirmed adverse event information is used as an opportunity to improve services. Neurological observations are not being undertaken for unwitnessed falls.	Provide evidence that adverse event information is used to improve services. Provide evidence that neurological observations are undertaken for unwitnessed falls to meet policy requirements. 90 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 Low	The service has a system in place to identify, plan and facilitate ongoing staff education. There is an annual education calendar in place which shows that regular on-site staff education is presented including guest speakers such as for first aid and a physiotherapist for manual handling. Staff confirmed during interview that education is relevant to the scope of practice offered. The owner/director informs staff of any off-site education and information is placed on the staff notice board. Off-site education includes palliative care, ADHB annual education days, management related topics and 'Nikki' pump education. The recording of in-service education is kept with a signing sheet to say which staff have attended but the contents of the education was not available. Individual staff education hours have not been recorded for the past year. Not all staff appraisals are up to date and there is no system in place to identify when each staff member's appraisal is due.	Staff education/in-service training content is not available. Staff off-site education is not always recorded. There is no record kept for individual staff member's training hours. Four of seven staff files reviewed did not have up to date annual appraisals.	Provide evidence that all staff education is recorded for each staff member to accurately show the hours they have completed and that a copy of the content of education is available. Also that staff annual appraisals are to be up to date. 90 days

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA High	Policies that reflect safe best medication practice are in place. Medications are safely stored. Medication disposal is managed safely by the pharmacist. A resident admitted to the facility from an acute setting on the 19 July 2018 was charted Warfarin. The Warfarin dosage monitoring chart does not identify the therapeutic level for the international normalized ratio for blood clotting time (INR). Phone orders received by registered nurses for a change of warfarin dosage are not documented to meet safe practice requirements. There is no medical practitioners' signature for the change of medication orders. It was identified on the 27 July that the residents (INR) had risen to 4.2. Warfarin was to be withheld and vitamin K to be administered. The (INR) recheck was due the next morning. Conflicting correspondence is noted in the progress notes to say that the Warfarin was withheld and the medication signing sheet states that Warfarin had been administered. On the 28th July 2018 the resident visited his GP accompanied by a family member (no documentation of this visit was available). He returned with two newly prescribed medications which are not identified on the resident's medication chart. Staff continued to administer the non-charted medication to the resident. This medication is not being signed for as been given. The clinical nurse manager stated that this occurred over a three-day period. Though some improvement has been made the weekly control drug check remains unmet by the service. The pharmacist undertook a six-monthly controlled drug check audit on the 26 June 2018. The medication policy states the checking of controlled drugs must occur weekly; however, the stocktake of controlled drugs is occurring fortnightly when the pharmacist delivers the controlled drug medication.	There is no identified therapeutic range for INR. Staff have signed that Warfarin has been administered when it be requested that it be withheld. Non-charted medication is being administered. Weekly controlled drug checks are not occurring.	Provide evidence that all medication management is undertaken to meet safe best practice medication guidelines and policy. 1 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional	PA Low	The cook and staff interviewed stated that they know the residents likes and dislikes of food and alternatives are provided as required and/or required. The residents interviewed stated that they had a wide range of food options provided and were happy with the menu. The current menu was last reviewed by a dietitian in June 2013.	The dietitian has not reviewed the current services menu within the last two years.	Provide evidence that residents' nutritional needs are provided in line with recognised

guidelines appropriate to the consumer group.				nutritional guidelines. 90 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	Food procurement, production and preparation comply with current legislation and guidelines. The cook interviewed was aware of food safety guidelines. The kitchen observed at the time of audit was clean and tidy. The cook interviewed stated that there was not a cleaning schedule for the kitchen and the cleaning was not signed off as completed but that cleaning does occur on a daily basis. At the time of audit, the owner/manager printed of a copy of the cleaning schedule and signing sheet which was then sighted as commenced on the day of audit.	A cleaning schedule and signing sheet was not available in the kitchen.	Provide evidence that the cleaning schedule for the kitchen is available and signed by staff to show that cleaning in the kitchen is implemented. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The staff interviewed stated that they know the residents well and information is provided about changes to the residents at staff handovers. Information was recorded in residents' progress and GP notes and long-term care plans identifying the residents with an increased risk of and/or frequency of infection. One resident admitted in 2013 has had two recent infections, two residents (one admitted in October 2016 and one in April 2018), have each had three infections recorded, and one resident admitted in September 2017 has had seven infections recorded between December 2017 and the current date. All identified residents did not have supporting short term care plans evidenced. .	Of the 10 residents' files reviewed, four residents with infections did not have a supporting short-term care plan.	Provide evidence that short term care plans are completed to meet policy and best practice standards. 90 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated	PA Low	The activities co-ordinator and care staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and families confirmed their involvement in the assessment process and care provided. The activities co-ordinator provided evidence to show that evaluations of the residents and the activities they are attending is	Residents do not have a social profile assessment or care plan	Provide evidence that a social profile and activities care plan is

to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.		regularly reviewed. Ten of the ten residents' files reviewed did not have an activities social profile or assessment completed to identify the resident's interests.	completed for activities.	completed for all residents. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.