Care Alliance 2016 Limited - Waimarie Private 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:	Care Alliance 2016 Limited
Premises audited:	Waimarie Private Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 September 2019 End date: 23 September 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: 34

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

Waimarie Private Hospital provides rest home and hospital level care for up to 52 residents. The service is operated by Care Alliance 2016 Limited and is managed by a business manager, facility manager, senior manager (clinical) and a clinical coordinator. Residents and family/whanau 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 (DHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers, staff and a general practitioner.

The audit has resulted in six areas being identified as requiring improvement. These relate to quality and risk management, human resources management, currency of interRAI assessments and medication competency assessments. Three of the four areas from the previous audit have been addressed.

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.

Open communication between staff, residents and families is promoted, and 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, mission statement, philosophy and moto of the organisation. Monitoring of the services provided to the owner/director (business manager) is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data. 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 are current.

The appointment, orientation and management of staff is based on current good practice. There is ongoing education undertaken by staff which supports safe service delivery. Staff have annual individual performance reviews.

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 of service delivery and promotes a team approach to care delivery. The registered nurses are responsible for the assessment, planning, provision, evaluation, review and discharge processes. Residents have interRAI assessments completed prior to entry and three weeks after entry to the service. When there are changes to the resident's needs, a short-term plan is developed and integrated into a long-term care plan as needed. All long-term care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs and interests of the residents as individuals and in group settings.

The on-site kitchen caters for residents. Specific dietary likes and dislikes are accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met. A food control plan has been approved and is displayed.

An appropriate medicine administration system was safely observed at the time of the audit. A process is in place to ensure safety for a resident who self-administers their own medicines.

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. Required maintenance is undertaken.

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 a non-restraint policy. There are policies and procedures that support safe minimisation of restraint should it be required. No enablers or restraints were in use at the time of audit. Staff demonstrated a sound knowledge and understanding of the non-restraint policy.

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 undertaken monthly. Results of surveillance are analysed to assist in promoting infection prevention and reduction. The surveillance results are appropriately reported to staff and management in a timely manner. The surveillance programme is appropriate to the service setting.

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	13	0	3	1	0	0
Criteria	0	34	0	5	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
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 access complaints forms and how to make a complaint. The complaints register reviewed showed that one complaint had been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Residents and family members stated they were kept well informed about any changes to their 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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English at the time of audit. Auckland hospital staff ensure interpreter services are provided for

conducive to effective communication.		interim care residents as appropriate. The service has a monthly newsletter which is provided to all residents and family members to keep them informed of matters of interest related to what is occurring around the facility such as activities and upcoming outings.
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. A sample of monthly reports to the business manager (owner/director) showed adequate information to monitor performance is reported including occupancy, resident and staff issues, emerging risks and issues. The business manager actively works at the facility and is aware of all activities on a day to day basis. The service is managed by a facility manager who is a registered nurse and he holds relevant qualifications and has been in the role for almost two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing education and attendance at age care study days and DHB age care cluster group meetings. The service holds contracts with Auckland District Health Board (ADHB) for respite, rest home and hospital level care and rehabilitation. On the day of audit there were 34 residents being 18 hospital level care, nine rest home level care, two respite and five interim care residents who are hospital level. Twenty-seven residents were receiving services under the Age Related Residential Care contract, two residents were receiving services under the Long Term Support Chronic Health Conditions Residential Care contract and five residents were receiving services under the ADHB Interim Care Scheme at the time of audit.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement	PA Low	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections and pressure injuries. However, not all documented process is being followed. Management meeting minutes reviewed confirmed regular review and analysis of some quality indicators. Not all related information is reported and discussed at the staff meetings. Staff reported their involvement in quality and risk management activities through implementation of corrective actions. Relevant corrective actions are verbalised and documented on the handover sheet at each shift change and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (May 2019) showed no concerns were reported. The facility manager and the business manager confirmed any issues

principles.		raised would be addressed immediately. This was confirmed in a documented corrective action plans from issues raised at the previous audit which identified all corrective actions have been completed by the service within the required timeframes. 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 based on best practice and were current. The service has a four year review time for policies and the facility manager is currently developing a timetable to ensure policies are all reviewed within the required timeframe. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The management team are familiar with the Health and Safety at Work Act (2015) and have implemented requirements.
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	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to management and staff. The facility manager described essential notification reporting requirements, including for pressure injuries. Management advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests, issues based audits and any other notifications made.
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	Documented 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 confirmed the organisation's policies are being consistently implemented and records are maintained. 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 showed documentation of completed orientation and a documented performance review annually. The facility manager has a documented record of when staff appraisals are due. Continuing education is not planned or well documented. Mandatory fire training occurs six monthly, medication

		management competencies and manual handling annually. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. 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 appraisals related to 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. An afterhours on call roster is in place, 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 members 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 hour/seven days a week (24//7) RN coverage in the facility. The facility manager (RN) works three days a week from 7am to 3pm and is on call. The clinical coordinator (RN) works Monday to Friday 9am to 5pm and is on call. The business manager (owner/director) works at the facility Monday to Friday and is on call. Dedicated kitchen staff cover from 7am to 6pm seven days a week and dedicated cleaning staff work 10.5 hours per day Monday to Thursday and five hours Friday and Saturday. Two diversional therapists cover Monday to Friday activities.
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 medicine management policy is current and identifies all aspects of medicine management in line with the Medicine Care Guide for Residential Aged Care. A safe system for medicine management using an electronic system was observed on the day of the audit. The staff observed demonstrated good knowledge and had a clear understanding of the role and responsibilities related to each stage of medicine management. Staff who administer medicines have not all completed the required annual competency as per the training records reviewed and interview with the clinical coordinator. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The annual practising certificates and the pharmacy license were validated and records were maintained annually. The RNs check the medications against the prescription when delivered from the pharmacy. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request and six monthly medication audits are performed by the pharmacist. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six monthly stock checks and

		accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted included verification of the prescribers' registration number on the electronic system. All requirements for pro re nata (PRN) medicines are met. The required three monthly GP reviews were consistently recorded on the electronic medicine chart. Standing orders are not used. There was one resident who self-administers medications at the time of the audit. Appropriate processes were in place to ensure this was managed safely. There is an implemented process for comprehensive analysis of any medication errors.
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.	FA	The food service is provided on site by a three cooks team who cover the week. There is a kitchen hand that covers each day to assist the cook. The menu follows four-week summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at the time have been implemented. All aspects of production, preparation, storage and disposal comply with current legislation and guidelines. The cook provided evidence of food storage, cleaning schedules and maintenance of the kitchen environment and equipment meeting all requirements. This was an area identified for improvement at the previous audit which has been addressed. The manager orders and purchases all food. Food temperatures, including high risk items are monitored appropriately and recorded as part of the food service planning. The kitchen staff have all completed a safe food handling qualification and this was reviewed in the training records. The food control plan is dated expiry 15 January 2021 and is displayed in the reception. A nutritional assessment is undertaken for each individual resident on admission by the registered nurse and a dietary profile is developed. The personal food preferences, any special diets and/or modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's needs is available. Evidence of resident satisfaction with meals was verified by residents and family members interviewed and from resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the three dining areas at meal times to ensure appropriate assistance is available to residents as needed.
Standard 1.3.4:	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening as a means to identify any deficits and to inform care planning. The sample of care plans

Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.		reviewed had an integrated range of resident-related information. All initial assessments were completed and this was an area of improvement in the previous audit which has been closed out. The interRAI assessments are not all current and this is referenced to (1.3.3.3).
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, observation and interviews verified the care provided to residents 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. The GP interviewed, verified that medical input is sought in a timely manner, that medial orders are followed and care is well manged. Care staff confirmed that care was provided as outlined in the documentation. 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.	FA	There are two diversional therapists (one of whom works as an HCA) who provide the activities programme for the residents at Waimarie Private Hospital. Both hold the National Certificate in Diversional Therapy. The diversional therapist (DT) interviewed has worked at this facility since 2006. A social assessment and history is undertaken when the resident is admitted to the facility to ascertain resident's needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated six monthly and as part of the formal six monthly care plan and multidisciplinary review. Activities are varied and are provided in a group situation or one-on-one. The programme reviewed reflected resident's goals, ordinary patterns of life and include normal community activities. Residents and families are involved in and can attend the activities whenever they like. They can also attend the residents' meetings held monthly. The DT's also develop a monthly newsletter of events and up and coming celebrations or outings and a copy is sent out to all families and the residents receive a copy. Residents interviewed confirmed they find the programme fun and interesting and speak highly of the DTs and care staff who assist with activities when able and in the weekends.
Standard 1.3.8: Evaluation Consumers' service	FA	Residents' care is evaluated on each shift and reported in the progress records reviewed. If any changes occur the care staff report to the registered nurse on duty. Formal care plan evaluations occur six monthly in conjunction with the six monthly interRAI re-assessments or

delivery plans are evaluated in a comprehensive and timely manner.		as residents' needs change (refer to 1.3.3.3). Where progress is different from expected the service responds by initiating changes in the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for wounds and urinary infections. When necessary for unresolved problems long term care plans are added to and updated. Residents and families interviewed provided examples of involvement in evaluation or progress and any resulting changes. Family members interviewed verified that they were always contacted when a change or incident occurred involving their relative. A family/whanau communication record is maintained in all resident records reviewed.
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 30 June 2020) is publicly displayed. Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed and observation of the environment. The environment was hazard free, that residents were safe and independence was promoted. Maintenance repairs are followed up and signed off when completed. The three items of maintenance that required follow up as identified in the previous audit have all been undertaken and the criterion is now fully attained. Staff, residents and family members confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they were happy with the environment.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Surveillance is appropriate to that recommended for a long term care facility with infection definitions reflecting a focus on symptoms rather than on laboratory results. This includes urinary tract infections, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and skin infections. When an infection is identified a record of this documented on the infection reporting form reviewed. The clinical coordinator is the infection control coordinator (ICC) and reviews 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 at staff meetings and at staff handovers. Graphs are produced that identify any trends. Any new infections and required management plans are discussed at staff handover to ensure early detection occurs. Surveillance results are then shared with staff at the staff meetings. There have been no outbreaks of infection since the last audit.
Standard 2.1.1: Restraint minimisation	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 should they be required. Policy is being met

Services demonstrate that the use of restraint is actively minimised.		related to maintaining a restraint free environment. No enablers or restraints were being used at the time of audit as confirmed by observation, staff and management. The restraint coordinator (FM) would provide support and oversight for enabler and restraint management in the facility, should it be required. Policy identifies enablers as the least restrictive and used voluntarily at their request.

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 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	Key components of quality service delivery are explicitly identified in policy. These included the reporting of incident and accidents, complaints management, infection control, health and safety and restraint management to the business manager. However, not all these issues were documented in the reports sighted. The facility manager and the business manager said they were discussed but not documented.	The only key components of service delivery which are clearly documented and reported are related to incidents and accidents and health and safety.	Provide evidence that all key components of service delivery are reported to the business manager to show how they are linked to the quality management system described in policy. 180 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and	PA Low	Quality improvement data are collected and analysed but not evaluated or trended. The results of quality data collected is not all communicated to staff at monthly meetings. The facility manager stated any findings are communicated to staff on a day to day basis, but this information is passed on verbally. This was confirmed during staff interviews.	Meeting minutes showed that the only quality results reported at staff meetings related to incidents and accidents and challenging behaviour.	Provide evidence that all quality data is evaluated and trended and that information is communicated to all service providers.

evaluated and the results communicated to service providers and, where appropriate, consumers.			Quality data results are computerised on a monthly basis but there is no evaluation identified and no trending against previously collected data is undertaken.	180 days
Criterion 1.2.3.7 A process to measure achievement against the quality and risk management plan is implemented.	PA Low	The process used to measure achievement against the quality and risk management plan implementation is the internal audit process. There is a documented audit programme in policy which is not being followed. The facility manager has developed a shortened version of the internal audits to be undertaken but this occurs on an ad-hoc basis as there are no set dates shown for when each audit is to be undertaken. The facility manager is aware that audits requires 'a catch-up' and he stated he was working on this.	The internal audit requirements set out in policy are not being followed so it is difficult to ascertain a true measure of achievement against the quality and risk plan.	Provide evidence that the internal audit plan shown in policy is being maintained. 180 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	Staff undertake education on-site and off-site. There is no education plan in place, but staff are made aware of relevant off-site training as it becomes available. On-site education is undertaken for mandatory training such as fire evacuation drills (six monthly) and manual handling annually. The health care assistants who had not completed a NZQA qualification were assisted to undertake a year-long programme which has given them an advanced diploma in health. Four staff attended this during 2018-2019 with completion occurring in August. Education undertaken on site is shown on the computer, but it is not documented in staff files and it is very difficult to know who has attended each training session. Staff confirmed during interview they are trained according to their level of competency and that if they ask for in-house education a session is always organised. Staff are looking forward to the on-line training which the provider	There is no education plan in place which identifies ongoing education. Documentation in staff files does not identify what training and education each staff member has attended for 2018-2019.	Provide evidence of documented planned, appropriate ongoing staff training and education and that attendance is documented in each staff member's file. 180 days

		has purchased and is to commence in October 2019.		
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	The clinical coordinator was interviewed. Medication records were reviewed. Four of five RNs and seven healthcare assistants (HCAs) are medication administrators and two HCAs are 'checkers'. The medication training records reviewed evidenced training was provided for staff during the year on medication topics such as insulin management, warfarin management and other topics; however, training did not evidence that staff responsible for administering medications had completed the annual competency requirements.	Staff who administer medicines have not completed the required annual competency questionnaire and practicum for medication administration.	Provide evidence that all staff who administer medicines have completed the annual medication competencies required to perform the function for each stage they manage. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	Initial assessments within the first 24 hours are completed for all residents on admission. This was an area requiring improvement identified in the last audit (1.3.4.2) which has been addressed. However, the interRAI assessment summary was reviewed and it was evident that the residents' interRAI assessments were not up-to-date. One initial interRAI admission assessment had not been completed for a resident. This was also identified at the previous audit (1.3.3.3). Three registered nurses have interRAI competencies which were current. A schedule has been developed by the clinical coordinator which has recently been implemented. The care plans completed had not been signed and dated to evidence any input from the resident and or the family/representative.	The previous finding in the last audit has not been addressed. One resident admitted in July 2019 has not had the interRAI assessment completed in the required timeframe of three weeks post admission. Currently eight interRAI re-assessments are overdue. Care plans have not been signed off by the resident and/or family when updated.	Provide evidence that all interRAI assessments are up to date and that care plans reflect that the resident/family/representative have been involved with the development and implementation of the care plan. 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.