# Warkworth Hospital Limited - Warkworth Hospital

## Introduction

This report records the results of a Certification 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:** Warkworth Hospital Limited

**Premises audited:** Warkworth Hospital

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

**Dates of audit:** Start date: 1 July 2021 End date: 2 July 2021

**Proposed changes to current services (if any):** Building renovations are underway. Renovations include a new ramp, veranda, new fire exit, conversion of an internal room to a bedroom, two new bedrooms and more storage spaces. Once the renovation is complete there will be three new bedrooms added to the facility.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 37

# 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

Warkworth Hospital services are provided by Warkworth Hospital Limited. The organisation provides rest home and hospital care for up to 37 residents. Since the last audit renovations are underway to the building, these have included a new ramp to the front entrance, and a large deck. More renovations are planned. New electronic systems are being adopted, including quality management systems, human resources systems and patient management systems. There have been no changes to the organisational structure.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standards and the provider’s contract with the district health board (DHB). The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family/whanau, management, and staff. The general practitioner was unable to be interviewed.

## 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. |

Warkworth Hospital provides services in line with the requirements of the Code of Health and Disability Services Consumers Rights (the Code). Information about the code of rights and services is displayed and available to residents and families. Residents have access to advocacy services. Informed consent requirements are in place. There was evidence that residents’ individual values and beliefs are respected. All staff receive training regarding professional boundaries, and the Vulnerable Person Act. Residents and families interviewed spoke positively about the care and support provided. There is a Māori health plan in place to support practice and individual values are considered during care planning. Complaint processes are implemented, and complaints and concerns are actively managed and documented. Community links are supported and facilitated. Family members commented that they are happy with the visiting arrangements.

## 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. |

Warkworth Hospital is owned by two owners/directors. The service is managed by an experienced facility manager, who is a registered nurse (RN) and an experienced operations manager. The directors set the strategic direction and monitor organisational performance in collaboration with the managers.

There is a documented quality and risk management programme that supports the provision of clinical care. Quality and risk data is recorded and shared with staff and management. Quality data collected covers the key components of service delivery. Internal auditing enables the service to monitor systems and processes and identify areas for improvement. The adverse event reporting system complies with the service’s policy. Staff document and report adverse, unplanned, or untoward events. Resident records are secure and include the required information.

Human resources practices are implemented. The staffing skill mix is appropriate for the level of care and services provided.

## Continuum of service delivery

|  |  |  |
| --- | --- | --- |
| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

Residents are assessed prior to entry to the service to establish the level of care. The processes for assessment, planning, provision, evaluation, review, and exit are provided by suitably qualified staff. The clinical manager and registered nurses assess and develop care plans in consultation with the residents and their family. The resident’s need and care requirements are evaluated as required. The required personal care and clinical interventions are implemented. The planned activities are meaningful to the residents, and aim to develop and maintain residents’ strengths, skills, resources, and interests. Medication is managed via an electronic platform. Medications are administered by the nursing team with current medication competencies. Medication charts are reviewed by the general practitioner (GP) three monthly and as required. An improvement is required to ensure PRN medication held in stock has documented expiry dates.

Meals are cooked on site and the menu meets cultural requirements, preferences, and requests. There was a food control plan certificate in place and the dietitian had reviewed the menu.

## 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 and approved evacuation plan. Ongoing maintenance and compliance monitoring ensure that the physical environment meets the needs of the residents and health and safety requirements. Electrical and medical equipment, furniture and fittings are maintained in safe working order. Emergency management plans and equipment are in place, annual maintenance and calibration checks are maintained by an external contractor. All residents’ rooms provide privacy, there are two shared rooms. There are sufficient communal areas within the facility, and the garden, for residents to enjoy. Outdoor areas are maintained to ensure safety. There are documented cleaning and laundry procedures. Personal protective equipment is readily available. Appropriate orientation, information, and equipment for responding to emergencies are provided. All laundry is washed on site. There are appropriate monitoring systems in place to evaluate the effectiveness of the housekeeping and laundry services.

There is a construction project in place outside the facility, with a planned addition to the facility to increase bed numbers, service, and storage areas. The project plans have been approved by the authorities concerned. The safety precautions in place comply with health and safety standard requirements for construction.

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

The required processes for the minimisation and safe management of restraints and enablers are in place. There were no residents using restraints during the audit. Staff received the required training. There was one resident using an enabler, the required documentation is to be provided.

## Infection prevention and control

|  |  |  |
| --- | --- | --- |
| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Some standards applicable to this service partially attained and of low risk. |

The infection prevention and control management system are in place to minimise the risk of infection to residents, visitors, and other service providers. The infection control coordinator is responsible for coordinating education and training of staff. The required policies and procedures are documented. The infection control surveillance and associated activities are appropriate for the size and complexity of the service. The Infection Control Nurse reported Infection data is collected monthly and reported during staff meetings. There were no records sighted on the infection control education/training to the staff. Refer (1.2.7.5). An improvement is required regarding the infection control surveillance documentation, and record keeping.

## 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 | 41 | 0 | 4 | 0 | 0 | 0 |
| **Criteria** | 0 | 89 | 0 | 4 | 0 | 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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Staff interviewed demonstrated knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). Staff orientation and the annual in-service education programme includes information about the Code. Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents. Residents interviewed reported that they are treated with dignity and respect and their rights are observed. The relatives interviewed reported that residents are treated with respect and dignity. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The residents' files reviewed had consent forms signed by the residents, or when appropriate, signed by the enduring power of attorney (EPOA). Two resident files reviewed included Advanced Care Directives and wishes for end-of-life care. Staff acknowledged the residents’ right to make choices based on information presented to them. Observations during the audit confirmed that staff seek consent from the residents on day-to-day matters. Family members and residents interviewed confirmed they are actively involved in their recovery, care, treatment, and support for decision making and provided with appropriate information. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and family/whanau reported that they are provided with information regarding access to advocacy services. Family members nominated by the residents or external advocates may act as advocates for residents. The service has an advocacy policy. Contact details for the Nationwide Health and Disability Advocacy Service are listed in the resident information booklet and pamphlets are available at reception. Education on advocacy and support is conducted as part of orientation and as part of the in-service education programme. A health and disability advocate provides in- service training for staff. The HDC were unable to provide training in 2020 and the beginning of 2021 dur to Covid 19 restrictions. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | Residents confirmed in interview that they have access to visitors of their choice. Family members confirmed they are happy with the visiting arrangements. The management confirmed that the facility asks visitors to refrain from visiting before 11.00am for the resident’s privacy, if they wish to visit before 11.00am, they will speak with staff on duty. There is no restriction to visiting when a resident is palliative. Residents are supported and encouraged to access the community as part of the planned activities programme. The facility uses a van and a car for community outings. |
| 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 procedures are in line with the Health & Disability Commissioner’s Code of Health and Disability Consumers’ Rights (the Code). Residents and their families are provided with information about the complaints process during the admission process. Information about the residents’ right to complain is displayed. Complaint forms are situated on the reception desk. Residents and family members interviewed confirmed their knowledge of the complaints process.  Communication with the complainant is maintained in the complaints register. The last formal complaint was in June 2018. The complaint was included in the register. The register included the required information and confirmed that the complaint had been resolved in a timely and appropriate manner, in line with the Code. The operations manager and facility manager confirmed that complaints are used as an opportunity to improve services as required. Complaints are a standing agenda item for staff meetings. A resident and a family member interviewed confirmed the management is accessible and responsive if a concern or query is raised. Residents are also provided the opportunity to raise any concerns, and provide feedback, during the residents’ meetings. Records of the residents’ meetings included feedback from residents regarding day to day matters such as laundry, meals, and activities. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Information about the Code, advocacy services and the complaints process are provided on admission and displayed at the reception and at the entrance to the facility. The Code is available in Maori and English, respectively. Residents and families interviewed were aware of their rights and it was confirmed that information was provided to them during the admission process. Warkworth Hospital’s information pack was also sighted and there is a website which outlines services provided. Admission agreements were signed in the resident’s records reviewed. Information about advocacy services is provided to residents and their families, and staff were aware of how they could access advocacy services if required. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The privacy and dignity policy provides information on the service’s processes for ensuring the privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents’ related information.  The process for accessing personal health information is detailed. The care planning process identifies and records interventions for respecting residents’ individual beliefs and values. There are two shared rooms and 33 single rooms. It was noted that the service maintained the physical, visual, and auditory privacy for residents. Personal property is maintained in a secure manner. Policies and procedures on abuse and neglect include definitions and reporting requirements.  The service identifies, respects, and responds to the needs, values, beliefs, cultural, religious, social, and/ or ethnic group that residents identify with. Resident’s documentation included identification of these needs and plans to respond to the needs identified. Interviews with residents, their families and staff demonstrated that the service is responsive to cultural needs. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. Family/whanau / next of kin input and involvement in service delivery/decision making is sought if applicable. The staff interviewed reported that they understand and have attended cultural training and demonstrated the importance of culturally appropriate care to Maori residents. A Maori health plan is documented. The services of a kaumatua are accessed as required.  A Maori resident and their family member interviewed described the activities the service has undertaken to respond to their cultural values and beliefs. It was confirmed that the service actively involves whanau, with the resident’s consent in the assessment, care planning, review, and evaluation process. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The cultural and spiritual needs of residents was identified in residents’ files reviewed as appropriate. This information is obtained in consultation with the resident and family as part of the admission process. Specific health issues and food preferences are identified on admission. The care plan is developed to provide guidance on delivery of individualised support in a culturally and/or spiritually sensitive manner. Staff interviewed confirmed they work with the residents to ensure their individuals’ culture and values are respected. The residents reported that cultural and religious beliefs are respected and that there is access to church services, and community groups. The priest and a minister visit the site to provide religious support to residents. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The employment position description and the Code define residents’ rights relating to discrimination. Staff interviewed confirmed they would report any discrimination, coercion, harassment, sexual, financial, or inappropriate behaviour to the facility manager. The facility manager reported that formal action is taken as part of the disciplinary procedure if there was an employee breach of conduct. The facility manager confirmed that the service would respond to any discrimination, abuse, or neglect, and that the service supports the role of the NZ Police in investigation of suspected abuse. Referral to other agencies may occur as appropriate. Legislative and reporting requirements are described in the ‘Abuse and Neglect Policy.’ |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The planned annual education programme sighted included sessions that cover topics required for best practice. Specialist advice from external providers is available if required. There is in-service education and staff access external education that is focused on aged care, dementia care and best practice. Six caregivers are accessing external education at present, and they are studying various NZQA levels in health and wellbeing of the older adults. Staff reported satisfaction with the staff development input provided.  Policies and procedures are linked to evidence-based practice. There are regular visits by the general practitioner (GP) and links with the local district health board. A request was made to the GP for an interview to be conducted during the audit, unfortunately the GP was unavailable. The organisation is a member of the New Zealand Aged Care Association (NZACA) and the facility manager attends NZACA meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Incidents and accidents were documented and reviewed on the event report analysis forms. Family/whanau reported they are informed of any accident or incident, and this is documented in the family contact event notes. Staff, residents, and family members interviewed confirmed that the environment is conducive to effective communication.  Staff education has been provided related to appropriate communication methods. The service has not required any access to interpreting services for the residents. Policies and procedures are in place if interpreter services need to be accessed, Google translator is used and the Waitemata DHB interpretation services are used as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Warkworth Hospital provides rest home and hospital level care for 37 residents. There are 26 designated hospital level beds, and 11 swing beds which can be used for residents who require either rest home of hospital level care. On the day of the audit there were 37 residents. This consisted of eight rest home residents and 29 hospital residents. There were four residents under the age of 65 years.  The mission statement and purpose are documented. Strategic planning is undertaken at a governance level each year. Annual business goals are documented. The business strategy includes additions to the service which are planned to occur over the next few years.  The hospital is governed by two owners/directors and managed by a facility manager and operations manager. The facility manager is an experienced RN, who has been in the role for 15 years. The operations manager has previous experience in the health sector and has been in the role for 13 years. The managers regularly liaise with the directors. Records of these meeting confirmed discussion regarding business and operations. The management team attend the required hours of education and training covering clinical and management topics. The facility manager has recently attended the national aged care conference. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | Management duties are shared between the facility manager (RN) and operations manager. There is a senior registered nurse who fulfils the facility manager’s role in the event of their temporary absence. One of the directors is also available to meet business requirements. |
| 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 principles. | FA | Warkworth Hospital has a has a quality and risk management plan which is designed to monitor contractual and standards compliance. Policies and procedures are current, reflect best practice guidelines and legislative requirements and are available to guide staff. There is an archive system in place for obsolete documents. The management team take joint responsibility for updating documents. All documents are controlled, and password protected. There is a mechanism for alerting staff to new documents; staff receive an email and a phone alert to advise them there are documents in place to be reviewed. Staff must acknowledge they have received and reviewed these documents. Policies and procedures are updated in an ongoing manner.  Quality goals are documented. Achievement towards quality goals is reported to the directors. A range of quality data is collected. This includes internal audits; resident satisfaction; adverse events; health and safety; restraint; complaints and infection control. Data and corrective actions are used to improve services where opportunities for improvement are identified. There is a process for communicating quality activities to staff, this occurs at staff handovers and at staff and registered nurse meetings. These meetings include issues, suggested actions and outcomes.  Actual and potential risks are identified and documented in the hazard register and in the risk management plan. Hazards and risks are communicated to staff and residents as appropriate. Hazard boards displayed on site included the hazards identified as part of the construction process. Hazards on site during the day were isolated. Risk management processes are reviewed annually by the directors with input from the facility manager and the operations manager. |
| 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 | The facility manager and the operations manager confirmed their understanding regarding their obligations in relation to essential notification requirements including reporting under Section 31 of the Health and Disability Services (Safety) Act 2001. Adverse events are documented. Records of events sampled confirmed that actions and investigations were completed in an appropriate and timely manner. Remedial actions and improvements are made. There was evidence of open disclosure as appropriate. Staff interviewed confirmed they report and record all incidents and accidents.  A summary of adverse events is maintained and reported monthly. The facility is in the process of implementing an electronic patient management system which includes adverse events. This will enable the service to review reports and trends. Summaries of events and trends are provided by category and shared with staff at staff meetings. |
| 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 | Policies and procedures identify good employment practice; reflect good practice and meet requirements. Job descriptions describe staff responsibilities and accountabilities.  Seven staff files were sampled. Files sampled demonstrated that staff had completed an orientation programme appropriate to their role. The orientation programme includes the key requirements for service delivery and emergency management. Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in staff files sampled.  Orientation and induction had been completed and this was documented in staff files. There is an annual education calendar for on-site education. Mandatory topics include consumer rights; infection prevention and control; manual handling; restraint and emergency management. The facility manager explained that due to Covid 19 limitations not all mandatory education sessions have been undertaken in the past year. The service was unable to provide documented attendance that staff had attended annual mandatory education sessions which included infection prevention, and consumer rights. (See Link 3.5.7.) The facility has recently commenced online training, this will enable staff to complete many aspects of mandatory training and enhance documentation of mandatory training.  Staff have undertaken external training sessions relevant to their roles, and training with Careerforce, Kalendra and Waitemata DHB. Evidence of this was sighted in files sampled. Registered nurses have attended a broad range of clinical education relevant to their role as was confirmed in their staff files. The service has three registered nurses who have completed interRAI training. There was evidence in their staff files that they had undertaken advanced nursing skills and medication competencies. All of the registered nurses have a current first aid certificate. The cleaners have had chemical safety training and kitchen staff complete food handling requirements.  Staff performance is monitored, and annual staff appraisals were sighted in staff files sampled. |
| 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 an appropriate staff rationale and skill mix policy in place. Sufficient staff are rostered to manage the care requirements of the residents. There is a combination of 12 and eight-hour shifts. Care givers and registered nurses are provided with set numbers of residents on their duty/task lists. These lists contain up to five residents per staff member. Care giver patients’ lists identify the resident name and acuity level.  The facility manager and operations manager attend the site Monday to Friday, during business hours. Two RNs and five care givers are rostered for morning shifts. One RN and an EN and four caregivers are rostered for afternoon shifts. Overnight there is one RN and two care givers. There are designated additional service staff such as: cleaners; laundry; activities and kitchen staff.  There is evidence that staff absences in the roster are filled. There are sufficient staff to safely cover shifts. The facility manager reported that the service anticipates they may experience a shortage in RN availability, despite recruitment initiatives being implemented.  Regular team meetings and registered nurse handovers/meetings ensure continuity between shifts. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Hard copy residents’ records are maintained. These are stored in a secure manner. Archived records are securely stored and accessible on site. Both the RNs and the care givers maintain progress and write an entry in the records every shift. All residents’ records sampled included the name and designation of the writer. Records were integrated. Allied health and GP’s entries are included. All records were legible. A resident register is maintained for both the hospital residents and rest home residents. Medication records were maintained electronically. The service is intending on implementing an electronic patient management system and quality management system. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Resident files sampled confirmed that residents had been assessed as appropriate to enter the service prior to admission. the required level of care has been confirmed by the local Needs Assessment and Service Coordination Agency (NASC). Following admission relevant assessments were completed within required timeframes in a competent manner, and clearly communicated to residents/ family/, and referral agencies. All resident files reviewed contained signed and dated, admission agreements, that included a range of consents and services provided to the resident. Residents and family members interviewed advised they had received sufficient information about the service, and this was provided in a respectful manner. Registered nurses interviewed were able to describe the admission process and criteria. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | Exit, discharge, or transfer is managed in a planned and coordinated manner, with an escort /family member as appropriate. There is a documented process in place and open communication between all services, the resident, and the family. At the time of transition, appropriate information is provided to the person/facility responsible for the ongoing management of the resident. The service utilises a standard referral form when referring residents to other service providers. The resident and the family/whānau are kept informed of any transfer outside the facility as verified by documentation and interviews with families and residents. |
| 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 Low | The medication management process is well documented and aligned with legislation, guidelines, and best practice. The service uses an electronic medication prescribing and administration platform. All medication records contained a photograph of the resident and allergy status. PRN medications had indications and maximum doses, and short courses medications had a start and finish date. PRN medication administration included a reason for administration and the outcome has been documented by the FM and RNs. Medications are administered by the nursing team with current medication competencies. All medication records had been reviewed within the past three months by the GP. Medications are dispensed and delivered from a local contracted pharmacy. All medications are checked, and medication reconciliation is conducted by the FM and RNs. A medication round undertaken by an RN was observed, the principles of safe medication administration were followed. No residents were self-administering medication during the audit. A self-administration procedure is available, and covers the self-administration competency test, storage and consent taken, GP review and approval.  The safe management of missed medication and reporting of the medication incident process is followed if required. No reports had been received of missed medications or medication errors, this was confirmed by the FM. A weekly nursing audit is completed on medication charts. Weekly and six-monthly controlled drug stocktakes are conducted, pharmacist audits and signatures in the controlled drugs register were sighted. Monitoring of the medication fridge temperatures is conducted, and records were sighted. Medications are stored securely in the trolley and locked cupboards. No storage of vaccine occurs at the facility.  An improvement is required to ensure PRN medication held in stock has documented expiry dates. |
| 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 chief cook oversees the procurement of food, management of the kitchen and dietary services assisted by a cook and kitchen staff. The kitchen is adequately equipped. All meals are cooked on site, meals are served at a separate dining room, the temperature of food is checked before serving. On the day of audit, meals were observed to be hot and well-presented There is a four-weekly seasonal rotating menu in use, the registered dietitian has reviewed the menu within the last two years. The nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The residents’ weights are monitored monthly, and supplements are provided to residents with identified weight loss issues, evidence was sighted in files reviewed. Snacks and drinks are available for residents who wake during the night and on a 24-hour basis. The personal food preferences, cultural choice, any special diets, and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident’s nutritional needs is available. Evidence of resident satisfaction with meals was verified by resident and family interviews. Any areas of dissatisfaction are responded to, and action taken as confirmed by staff.  There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Checking of fridge and freezer temperatures, and kitchen inspections are completed, records were sighted. The kitchen was observed to be clean and tidy, food pending to be served was labelled, and food items stored in the fridge had current dates and labels. There were no expired food items in stock. The kitchen food safety handling training program, and food safety plan certificate were valid and sighted. Food management process complies with current legislation, and guidelines. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The facility manager (FM) and the RNs reported that the service documents when any residents are declined entry. When a resident is declined entry, family/whanau and the resident are informed of the reason for this and made aware of other options or alternative services available. The resident is referred to the referral agency to ensure that they will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Residents admitted to the service have an initial assessment completed within 24 hours. The initial assessment is comprehensive and utilises a range of assessment tools including but not limited to falls, skin, pressure area, dietary, pain assessment .and activities assessment. Files sampled evidenced ongoing assessment at six-monthly periods and more frequently if required. Family members interviewed advised that they had been notified when an updated assessment had been completed. All files sampled had a monthly recording of the resident’s vital signs and weight. Residents with diabetes had regular blood sugar levels documented. The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions in the reviewed files. Residents and families confirmed their involvement in the assessment process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans are resident centred, integrated and provide continuity of service delivery. The assessed information is used to develop long term and short-term care plans for acute needs. Goals are specific and measurable, and interventions are detailed to address the desired goals/outcomes identified during the assessment process. Care plans sampled are integrated and included input from the multidisciplinary team. The residents and relatives interviewed confirmed care delivery and support are consistent with their expectations and plan of care. All care plans sampled included detailed interventions to meet the resident’s current health status. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Short term and long-term care plans sampled included interventions appropriate to meet the residents' needs and desired outcomes. The care and interventions are regularly evaluated to ensure set goals are achieved. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as noted in the GP medical notes. Wound assessments are completed as required. Monthly observations are completed, and are up to date, including weight, blood pressure monitoring, and blood glucose monitoring. A range of equipment and resources were available, suited to the level of care provided and following the residents’ needs. Staff confirmed they have access to the supplies and products they needed. |
| 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 a full range of social activities that are available on the weekly programme for all residents to participate in. All residents are assessed and invited to participate in specific activities that are appropriate for their level of ability, preferences, and interests. The programme also identifies activities that are suitable for the under 65 years of age residents. The activities can either be individual or group activities conducted by the activity coordinator, the activities are used to facilitate emotional and physical wellbeing. There were documented evaluations on the residents’ participation and the outcomes that residents are achieving from these.  Planned activities include, but are not limited to outings, bingo, painting, singing, and walking groups, Community group visits and events celebrations take place. The activities coordinator has shown a good understanding of the activities provided; the residents were observed participating in a variety of activities on the audit days. The activities schedule is provided to residents. Clinical files sampled contained an activities assessment, and an individualised activity plan that complemented the long-term care plan. A review of the activities plan occurred as part of the six-monthly interRAI assessment and care plan review. Residents and family members interviewed confirmed they are consulted on the development of individual activity plans and reported overall satisfaction with the level and variety of activities provided. Maori residents participate in the planned activities as per their choice and preferences, include Maori music, watching Maori TV channel and family/whanau social activities, as confirmed by the activities coordinator and the Maori resident interviewed. The residents were observed participating in a variety of activities on the audit days. There are planned activities and community connections that are suitable for the residents. The residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | InterRAI and care plans sampled were reviewed at six-monthly intervals or more frequently when indicated, with evidence that changes were made following evaluation. Short-term care plans were evaluated regularly, with the care plan being signed off when the problem was resolved or integrated into the long-term care plan if required. Monthly measurements and checks were completed. Day-to-day monitoring and evaluation, when required, were reported in the clinical progress notes for each duty. When a resident’s health status changes the FM/RN is notified in the first instance and makes an assessment. If required, the GP or another health care provider as appropriate may be notified and requested to attend the resident. The FM covers after hours calls with 24-hour support from the operational manager (OP). Family members interviewed confirmed they were notified of any changes in the resident’s health status. The RN interviewed reported residents are reviewed regularly by the GP, the GP visits the facility once per week and as needed. The GP covers 24-hour on-call coverage as confirmed by the FM and RNs team, during the interview. Medication charts were reviewed and are completed 3 monthly and as required. Multidisciplinary meetings are held every six months on a regular basis. The auditor was not able to reach or communicate with the GP despite several attempts being made. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The FM, and GP facilitate and support residents to access or seek other health and/or disability service providers as required. The service has contracted GP services through a local medical centre, residents may choose to use other medical practitioners if desired. If the need for other non-urgent services is indicated or requested, the GP or RNs send a referral to seek specialist input. Copies of referrals were sighted. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. The service utilises a standard referral form when referring residents to other service providers. The resident and the family/whanau are kept informed of the referral process, as verified by documentation and interviews with family and residents. The referral process was confirmed by the FM and nursing team. (It was not possible to reach or communicate with the GP, several attempts were made during the audit.) |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. The operations manager is the designated maintenance person and ensures adequate stock is held onsite. The staff have completed the required chemical handling training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant staff training. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment, and the staff were observed using them. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is publicly displayed. Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. Hot water checks are conducted monthly, with all readings below the maximum temperature. Residents can walk around freely throughout the facility and grounds. Safety rails are secure and appropriately located in corridors, bathrooms, and toilets. Ramps and handrails are in place. External areas are safely maintained and are appropriate to the resident groups and setting.  Residents and staff interviewed confirmed they know the processes they should follow if any repairs or maintenance are required, any requests are appropriately actioned, and they are happy with the environment.  The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed by reports sighted, interviews with maintenance personnel, and observation of the environment. Efforts are made to ensure the environment is hazard free, that residents are safe, and independence is promoted.  There is a current construction project underway. This will include additional rooms, and spaces for storage and services use. All health and safety risks associated with the project have been identified, Safety precautions, displayed posters, project information’s and directions are in place. A certificate of public use by Auckland Council and the approval was sighted and is displayed. The contract manager for the DHB and Health Cert have been informed about the project, as reported by the operational manager and FM. The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents. visitors, and staff. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are an adequate number of toilets, bathing, and shower facilities to meet the needs of the residents. This was confirmed in interviews with residents, and as per tour of the facility. Toilet and showering facilities are private, in resident’s rooms or shared, and privacy is assured. Each bedroom has a hand basin. Hot water is monitored monthly, and records confirmed that the temperature remains consistent and within the recommended temperature. Wall linings in the wet areas are monitored for water tightness. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There is sufficient space in all residents’ rooms to allow care to be provided and for the safe use of mobility equipment. Staff interviewed reported that they have adequate space to provide care to residents. Residents are encouraged to personalise their bedrooms as viewed on the days of the audit. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Communal areas consist of a large lounge, smaller lounge and a dining area. Adequate access is provided to the lounges, sitting areas and dining areas. Residents were observed moving freely within these areas. Communal areas are of a sufficient size to accommodate all residents. There is adequate room for all activities. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a laundry with a clean and dirty separation. Household staff are responsible for laundry and cleaning services. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. Safe and secure storage areas are available, and staff have appropriate and adequate access to these areas as required; chemicals were labelled and stored safely within these areas; chemical safety data sheets or equivalent were available; appropriate facilities exist for the disposal of soiled water/waste convenient hand washing facilities are available, and hygiene standards are maintained in storage areas. Cleaning chemicals and hazardous materials are securely stored in locked cupboards and are labelled and monitored. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Policies and guidelines for emergency planning, preparation, and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in the preparation of disasters. These policies and guidelines describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service. The operations manager confirmed that trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service. The orientation programme includes fire and evacuation. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water supply requirements in excess of the standard requirements, blankets, mobile phones, and portable gas cooker, were in place and meet the requirements for the 37 residents at the service. Evening and night-time security checks are managed by the staff. The electrical equipment safety test log sighted was current. Emergency lighting is regularly tested. Call bells alert staff to residents requiring assistance. The call system check is done periodically by the installing company, and audits are completed regularly by the staff. Residents and families reported staff respond promptly to call bells. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | The building is ventilated and heated appropriately. A heating system has been installed. Residents’ rooms have an external window of normal proportions. The operational manager /maintenance manager interviewed reported the heating systems are running smoothly and that appropriate checks are performed. On the days of audit, the indoor temperature was comfortable. Residents and families confirmed the facilities are maintained at a comfortable temperature during the summer and winter months. Observations evidenced that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. |
| 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 | Warkworth Hospital has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residence, staff, and visitors. The programme is appropriate for the size and complexity of the organisation and is guided by a comprehensive and current infection control manual. The infection control program and manual are reviewed annually. The infection control coordinator (ICC) role and responsibilities are defined in a job description. The ICC is a registered nurse, who was not available for interview. The RN interviewed reported the service has access to external specialist advice from a GP and the DHB infection control specialists when required. The staff are made aware of new infections through daily handovers on each shift, and in progress notes. The facility requests that anyone who is or has been unwell in the past 48 hours with an infectious condition, not enter the facility. There is practice in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks reported, and infection control guidelines are adhered to. Staff interviewed demonstrated an understanding of the infection prevention and control program. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The ICC has appropriate skills, knowledge and qualifications for the role and has attended training related to infection prevention and control. Additional support and information are accessed from the infection control team at the DHB, and the GP as required. The ICC has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections. The RN interviewed reported Infection control reports are discussed at the management meetings and monthly staff meetings. The FM confirmed the availability of resources and access to DHB specialist to support the programme and any potential outbreak of an infection. There have been no outbreaks documented and infection control rules are adhered to. Covid-19 precautions and guidelines for staff, visitors and families are in place. The staff interviewed demonstrated an understanding of the Covid-19 restrictions and ICP program |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection prevention and control policies reflected the requirements of the infection prevention and control standards and comply with the relevant legislation. Policies were reviewed and included appropriate referencing. Hand washing and sanitiser dispensers were readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. The care delivery team, cleaning, and kitchen staff were observed following organizational policies, such as appropriate use of hand sanitisers, good hand washing technique and use of personal protective equipment. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The training education information pack is detailed and meets current best practices and guidelines. External contact resources included the GP, laboratories, and local district health board infection control specialist nurse. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. There is an understanding of outbreak management, visitors are warned of any outbreak, and advised to stay away until the outbreak is contained. The RN interviewed reported infection control annual training and Covid-19 education for staff is conducted during handover sessions and staff meetings. Staff interviewed demonstrated an understanding of the infection control practices, Covid-19 precautions, protective practices of hand hygiene, physical distancing, isolation, and the importance of personal protective equipment. Covid-19 educational posters for families and visitors are in place around the facility. There were no records available on the infection control education / training provided to the staff. Refer to link 1.2.7.5. |
| 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. | PA Low | The infection control programme is reviewed annually. The surveillance policy identifies the requirements around the surveillance of infections. The RN interviewed reported data on diagnosed infections (including laboratory results) is collated monthly and presented in the staff meetings and recommendations to reduce and prevent the spread of infections are discussed. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection, respectively as sighted in resident sample files. Residents diagnosed with an infection had short term care plans in place. In interviews staff reported that they are made aware of any infections through feedback from the RNs, verbal handovers, short term care plans and the progress notes.  An improvement is required regarding the infection control surveillance documentation, and record keeping. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | PA Low | There are documented processes to guide safe practice and restraint minimisation. Restraint and enabler use is a mandatory staff training topic. At the time of the audit there was one resident using an enabler and no residents using a restraint. The enabler was a bed rail, requested by the resident. Authorisation, assessment, monitoring, and review was not in place as per the Warkworth Hospital Restraint and Enabler policy. |

# 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 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is an annual education calendar for on-site education. Mandatory topics include consumer rights; infection prevention and control; manual handling; restraint and emergency management. Orientation and induction have been completed for all staff. The facility manager explained that due to Covid 19 limitations not all mandatory education sessions have been undertaken in the past year. The service was unable to provide documented attendance that staff had attended annual mandatory education sessions which included infection prevention and consumer rights. | Not all mandatory education sessions have been undertaken in the past year. The service was unable to provide documented attendance of education sessions which included infection prevention, and consumer rights. | Provide evidence that staff have attended mandatory education sessions which include infection prevention, and consumer rights.  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 Low | The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Indications for use were noted on ‘as required’ medications, allergies were clearly indicated, and resident photos were current. Administration records were maintained, and drug incident forms completed in the event of any drug errors. All medicines were reviewed every three months or as and when necessary. The service does not keep any vaccines. | PRN medication held in stock and individual medication bottles have no expiry dates. | Provide evidence that PRN medications have expiry dates.  60 days |
| Criterion 3.5.7  Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Low | The RN reported data on diagnosed infections (including laboratory results) is collected monthly including monthly and annual comparisons. Infection rates are presented in the staff meetings and recommendations to reduce and prevent the spread of infections are discussed. | There was no documented evidence of infection control surveillance data analysis, evaluation, and recommendations to assist in infection reduction and improvement being reported to management and staff. | Provide documented evidence that infection control data collected is analysed, evaluated, and reported to management and staff, and recommendations for reduction of infections and improvement opportunities are documented.  90 days |
| Criterion 2.1.1.4  The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | Restraint and enabler use is a mandatory staff training topic. There are policies and procedures in place to guide staff on the use of restraints and enablers. At the time of the audit there was one resident using an enabler. The enabler was a bed rail, requested by the resident. Authorisation, assessment, monitoring, and review was not in place as per the Warkworth Hospital Restraint and Enabler policy. | At the time of the audit there was one resident using an enabler. The enabler was a bed rail, requested by the resident. Authorisation, assessment, monitoring, and review was not in place as per the Warkworth Hospital Restraint and Enabler policy. | Ensure that authorisation, assessment, monitoring, and review are documented as per the Warkworth Hospital Restraint and Enabler policy.  90 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.