

# Avonlea Trust Board - Avonlea Hospital and Home

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## 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:

<b>Legal entity:</b>	Avonlea Charitable Trust
<b>Premises audited:</b>	Avonlea Hospital and Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 19 July 2018    End date: 19 July 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	39

# Executive summary of the audit

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## 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
Yellow	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
Red	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

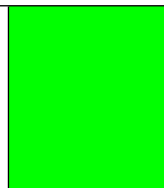
Avonlea Hospital and Rest Home provides rest home and hospital level care for up to 50 residents. The service is operated by The Avonlea Trust Board and is managed by a facility/nurse manager and a clinical nurse leader. There have no significant changes since the previous certification audit in 2016.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the Waikato District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, and a visiting social worker. No general practitioners (GPs) were willing to be interviewed. Residents and their families spoke positively about the care provided.

Corrective actions have resolved the three areas needing improvement at the 2016 certification audit, which related to analysis and evaluation of quality data, detail in controlled medicines recordings, medicine fridge and food temperatures. This audit identified four new areas requiring improvements. These relate to the timeliness of initial GP reviews, review and closure of short term care plans, storage of food and medicines and the competencies of staff stocktaking the controlled medicines. There is a rating of continuous improvement for achievements in governance.

## 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.



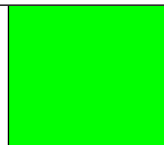
Standards applicable to this service fully attained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

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.



Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes internal audits, and the collection and analysis of quality improvement data. This data is benchmarked with eight other facilities and identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Policies and procedures support service delivery. These were current and are reviewed regularly.

Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided that meet the needs of the residents.

All residents have interRAI assessments completed and individualised care plans related to this programme. All care plans are evaluated at least six monthly.

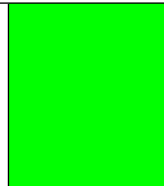
The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

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

A safe medicine administration system was observed at the time of audit.

## 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.

## 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.

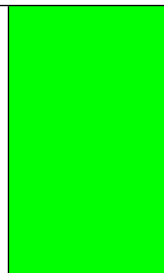


Standards applicable to this service fully attained.

Avonlea Rest Home and Hospital adheres to its policies and procedures which support the minimisation of restraint. There were thirteen restraints in use at the time of this audit.

## Infection prevention and control

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



Standards applicable to this service fully attained.

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

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	12	0	2	2	0	0
<b>Criteria</b>	1	34	0	2	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew what to do if they had concerns.</p> <p>The reviewed complaints register had five complaints recorded since June 2016 - one of these was an outgoing complaint from the facility. Letters of acknowledgement, ongoing communications and records of investigations are being completed within acceptable timeframes. A complaint from the local hospital to WDHB, was investigated by the DHB and the provider. The investigations were inconclusive. The provider has reviewed processes and implemented changes to minimise recurrence.</p> <p>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 known complaints to the Office of the Health and Disability Commissioner since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to 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 and the manager interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the</p>



<p>with consumers and provide an environment conducive to effective communication.</p>		<p>requirements of the Code. Staff knew how to access interpreter services, but this has not been required.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>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 reports to the trust board showed adequate information to monitor performance is reported including emerging risks and issues.</p> <p>The facility is managed by a nurse manager who holds qualifications and has been in the role for 12 years. Responsibilities and accountabilities are described in a job description and individual employment agreement. The manger confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through a post with the regional chapter of the NZ Age Care Association and regular meetings with other facility managers in the Community Trust Care Association (CTCA) group. CTCA is part of a business entity comprising nine aged care facilities who share common factors, such as being located rurally and governed by not for profit organisations. This has led to improvements in business operations and resident care.</p> <p>The service holds contracts with Waikato DHB for hospital-geriatric and medical, rest home, and respite care with a maximum capacity of 50 beds. On the day of audit there were 39 residents occupying beds. Thirteen were assessed as hospital level care, which included one person under the age of 65 and 27 rest home residents. Two of these were short stay/respite and one resident was at Waikato Hospital.</p>
<p>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.</p>	<p>FA</p>	<p>The organisation has an established quality and risk system that reflects the principles of continuous quality improvement. A part time quality officer manages the system. This includes collation and analysis of incidents, infections and complaints, carrying out regular resident and family satisfaction surveys and internal audits, and reporting outcomes. Where areas for improvement are identified these are documented and actions are monitored for implementation.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality data and benchmarking with eight other age care facilities. This and the work completed by the quality officer provides sufficient evidence to address the previous requirement for more detailed analysis and evaluation of quality data. Analysis of urinary tract infections (UTIs) identified a data error from over reporting. This has significantly reduced the overall rate of UTIs.</p> <p>Quality data and information is reported and discussed at regular health and safety, infection control, restraint and quality and risk team meetings, and general staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, training and information shared at meetings. The manager notifies all staff of corrective actions or policy/process changes by memos and verbally at meetings. Review of</p>

		<p>the most recent resident and family satisfaction surveys revealed no significant issues and moderate to high satisfaction.</p> <p>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 document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>There is a current risk management plan which is monitored by the manager and the Board. The manager is familiar with the Health and Safety at Work Act (2015) and described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed from 2016 to 2018 year to date revealed clear descriptions of the event, that the incidents were reviewed and investigated by the manager, and where necessary action plans developed. There was evidence that actions are monitored for implementation. Adverse event data is collated, analysed and reported to staff. Falls, urinary tract infections, skin tears and hospital admissions are benchmarked with the eight other facilities who belong to CTCA. Review of the comparative data showed a low rate of adverse events and a reduction in UTI's (refer Standard 1.2.3)</p> <p>The manger reported there have been no notifications to the Ministry of Health or the DHB and public health as per the Section 31 reporting requirements. There have been no significant events such as outbreaks, police investigations, coroner's inquests, or issues-based audits.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>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 five staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation followed by an initial performance review.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>The clinical leader is maintaining annual competency requirements to undertake interRAI assessments. Two other RNs have just completed their interRAI training.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented 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 interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, for the number of residents and their needs. There are adequate staff available to replace when there are unplanned absences. At least one staff member on duty has a current first aid certificate and there is 24//7 RN coverage.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management (using an electronic system) was observed on the day of audit however not all medication sighted was stored as per requirement. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required.</p> <p>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 stock check; however, the second checker (quality officer) has not completed their medication competency.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is not consistently recorded on the electronic medicine chart; however, evidence was sighted in residents' notes to show that this occurred. Standing orders are not used.</p> <p>There were no residents who were self-administering medications at the time of audit. There is an implemented process for comprehensive analysis of any medication errors.</p> <p>The previous audit identified an area for improvement to ensure that the controlled drugs had a weekly stocktake completed that records all information required, and the medication fridge temperatures were not</p>

		being monitored as frequently as required. Both areas have been addressed, and records were available to demonstrate this.
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The food service is provided on site by two cooks, one of whom is the kitchen manager, and supported by kitchen staff. The menu is in line with recognised nutritional guidelines for older people, follows summer and winter patterns, and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines; however, not all food sighted was stored appropriately. The facility has lodged documentation with the Ruapehu District Council and is awaiting a food safety guide certificate. A grade is pending as the facility is currently awaiting an inspection from the Council. The previous audit identified an area for improvement to ensure that food temperatures were taken for cooked meat. The corrective action has been addressed, and records were available to demonstrate this. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. All food is cooked on site and delivered to two dining rooms, with residents also provided with the option of eating in their rooms.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and in residents' 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.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of 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. The three GP's were unavailable at the time of audit to be interviewed. 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.</p>
<p>Standard 1.3.7: Planned Activities</p>	FA	<p>The activities programme is provided by one trained diversional therapist and an activities co-ordinator. The activities staff support residents from Monday to Friday 9.00 am to 5.00pm.</p>

<p>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.</p>		<p>A social assessment and history is undertaken on admission to ascertain residents' 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 three monthly and as part of the formal six- monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Several residents are independent and encouraged to connect and interact with the community, while other residents are supported by the staff and groups in the community to partake in regular community activities and groups. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and day to day discussions. Residents interviewed confirmed they find the programme interactive and fun.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and there is evidence of when changes occur documented throughout the ten residents' files reviewed.</p> <p>Examples of short term care plans were sighted for infections and falls; however, not all short-term care plans were consistently reviewed, and progress evaluated as clinically indicated. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>There is a current Building Warrant of Fitness (BWOFF) due to expire on 15 May 2019.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC</p>

<p>carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions (refer to criterion 1.2.3). Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Twenty-eight residents in April/May of 2018 consented to have the 'flu' vaccine.</p> <p>The facility averages 20 infections a month. Four residents have been identified as frequently requiring antibiotics for infections due to co-morbidities. A further two residents have been identified as requiring prophylactic antibiotics. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection, however not all short-term plans for infections had been reviewed and closed (refer to criterion 1.3.8.2). Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Data is benchmarked externally with eight other facilities within the CTCA group.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint register is being maintained and was current and accurate. On the day of audit there were 13 residents using bedrails and lap belts for safety reasons and/or to promote independent mobilisation. The service applies the same assessment, consent, monitoring and review processes for all safety interventions whether they are voluntary or not. A sample of two residents' records and observations confirmed that restraint documentation and the use of devices complies with this standard.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>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.</p>	<p>PA</p> <p>Moderate</p>	<p>The facility manager and clinical nurse leader interviewed could recall the proper procedures required when checking the controlled drugs weekly stocktake and the safe storage and disposal of medications no longer in use. The clinical nurse leader and quality manager check and document the controlled drugs weekly stocktake. The clinical nurse leader is medication competent, however the quality officer who has supported the clinical nurse leader as second checker in the controlled drug weekly stocktake for one year is not a registered nurse or medication competent.</p> <p>In observing the kitchenette fridge in the main hospital lounge/dining area, three liquid antibiotics for one resident were found with one of the antibiotics having expired. The clinical nurse leader when interviewed stated that the resident for whom the antibiotics were prescribed had deceased seven days prior. At the time of the audit the clinical nurse manager removed the antibiotics and organised them to be returned to the pharmacy.</p>	<p>Medication administration processes were not undertaken in accordance with the facility’s policy and good practice in relation to checking, storing and disposal of medication.</p>	<p>Provide evidence that all staff supporting medication management is medication competent and all medication is stored securely and disposed of as per medication guidelines.</p> <p>60 days</p>

<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Food procurement, production and preparation comply with current legislation and guidelines. The cook interviewed was aware of the guidelines. Not all food in the fridge of the hospital kitchenette, main kitchen freezer and chiller had food covered or dated. Food in dry stores is rotated but do not have dates written/recorded when transferred into new containers.</p>	<p>Not all food sighted in the main kitchen fridge/chiller and dry stores or hospital kitchenette fridge was labelled, dated and or covered.</p>	<p>Provide evidence that that storage of food complies with current legislation and guidelines.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	<p>PA Moderate</p>	<p>It was evident from staff interviewed that they knew the residents well. Family/whanau interviewed stated that they were happy with the care and communication provided. The admitting GP also knew the residents well as the residents belonged to one of the three GP practices prior to admission to the facility. One resident admitted to the facility on the 30 April 2018 was not admitted by a GP until the 31 May 2018. The clinical nurse leader confirmed that a resident admitted to the facility on the 1 May 2018 had been seen by the GP; however, not with the required timeframe and there was no evidence of any initial consultation GP admission notes. One resident was admitted on the 30 April 2018 and was not admitted to the facility by the GP until the 29 May 2018.</p>	<p>Not all residents were admitted to the facility by a GP within required time frames.</p>	<p>Provide evidence that each stage of service provision (assessment, planning, provision, evaluation, review) are completed within timeframes to meet contractual, legislative requirements and good practice.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the</p>	<p>PA Low</p>	<p>All residents had a short-term care plan specific and individual to the resident. Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. The clinical nurse leader stated that residents commenced on antibiotics are discussed at staff handover. Residents and families confirmed in interviews their involvement in the assessment process and stated that they were very</p>	<p>Not all short-term care plans sighted were reviewed and or evaluated.</p>	<p>Provide evidence that short term care plans are reviewed and evaluated.</p>



support and/or intervention, and progress towards meeting the desired outcome.		happy with the care provided. Five short term care plans were sighted in ten resident files for infections. Four of the five short term care plans were not reviewed and or evaluated on the short term care plan and/or progress notes.		180 days
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	CI	<p>Avonlea Hospital and Rest Home has joined eight other aged care facilities in the wider Waikato community who are governed by charitable trusts. The group formed a company, Community Trust Care Association (CTCA) in 2014 which received a finalist’s award for Business Innovation by an International Forum (Eldercare Innovation Awards) in 2017.</p> <p>The aims of the Trust are to work collaboratively and share resources in ways that sustain and support the individual trusts (eg, bulk purchase of products and supply agreements, benchmarking and information systems). A recent evaluation has proved cost savings, for example \$35,000 saved in continence supplies over a three-year period. Qualitative measures include enhancing all directors’ professionalism and overall improved governance, and gains from providing peer support for a range of employees who were previously working in isolation, for example, activities staff, clinical managers, and facility managers. The group is also working together to share methods and resources for staff education which has improved the frequency and calibre of ongoing staff training. There is now monthly</p>	<p>The benefits resulting from the formation of CTCA have been evaluated and proven using qualitative and quantitative measures. Residents have benefited from ideas for different activities generated at activities meetings, improved performance of managers and clinical nurse leaders who feel more supported in their roles and an increase in other staff skills and knowledge. This was witnessed on the day of the audit, when the manager sought advice and support from other facility managers.</p>

		benchmarking of adverse events which benefits each service by providing them with comparative data and using group intelligence to identify how to halt unwanted trends and replicate favourable trends.	
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End of the report.