# Waihi Senior Citizens Home Incorporated - Hetherington House

## 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 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](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:** Waihi Senior Citizens Home Incorporated

**Premises audited:** Hetherington House

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

**Dates of audit:** Start date: 1 August 2019 End date: 2 August 2019

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 49

# 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

Hetherington House provides rest home, dementia and hospital level care for up to 50 residents. The service is operated by the Waihi Senior Citizens Home Incorporated Society and managed by a Facility Manager (FM) with support from a long term employed Senior RN.

The FM has been in the role for 18 months and is very experienced in managing aged care facilities. There have been no changes to the scope or size of the services provided since the previous audit. Extensive interior upgrades and refurbishments have occurred along with acquisitions of furniture and chattels.

This certification audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family, management and a board member, staff, and a general practitioner. All interviewees including residents and their families spoke positively about the care provided.

This audit resulted in two areas requiring improvement. These are related to overdue interRAI assessments and storage of chemicals.

## 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. |

Residents and their families are provided with information about the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident’s needs.

A complaints register is maintained with complaints resolved promptly and effectively. There is one complaint that is not as yet closed out. The complaints management system meets regulatory and legislative requirements and was known by staff, residents and family members. Each of the concerns/complaints received had been managed in a fair and timely manner and was effectively resolved.

## 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. |

The strategic/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.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery. A pre audit review revealed that these reference best practice, are current and reviewed regularly.

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

Residents’ information is accurately recorded, securely stored and not accessible to unauthorised people.

## 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. |

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident and their family.

The multidisciplinary team, including a registered nurse and general practitioner, assesses residents’ needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with the meals.

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

The facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances, soiled linen and equipment is well managed. Staff use protective equipment and clothing. Chemicals are stored safely when not in use. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

|  |  |  |
| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The organisation has implemented policies and procedures that support the minimisation of restraint. Four restraints and three enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## 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 | 48 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 99 | 0 | 2 | 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 | The facility has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers’ Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records. |
| 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 | Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation’s standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the residents’ records. Staff were observed to gain consent for day to day care. The records reviewed of residents in the dementia service evidenced enduring power of attorney (EPOAs) documentation and these were activated appropriately. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. One family member interviewed had a relative in the dementia service and visited regularly at different times of the day. The family member reported that residents were always well supported by staff/ family/whānau and /or representatives. |
| 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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.  The facility has unrestricted visiting hours and encourages visits from residents’ family and friends. Volunteers from the community visit on a regular basis. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Residents and family have access to different lounges, to the outside garden and seating areas located near all service areas. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed understood how to raise these.  The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The FM is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussions with staff. The Code is displayed in the main reception area together with information on advocacy services, how to make a complaint and feedback forms. |
| 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 | Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.  Staff were observed to maintain privacy throughout the audit. All residents have a private room. The facility manager is the designated privacy officer.  Residents are encouraged to maintain their independence through community activities, arranging their own visits to the doctor, and participation in clubs of their choosing. Care plans included documentation related to the resident’s abilities, and strategies to maximise independence.  Records reviewed confirmed that each resident’s individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.  Staff understood the service’s policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. |
| 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 | Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. The senior registered nurse interviewed reported that there was one resident who affiliated with their Māori culture at the time of audit. There are nine staff who identify as Māori. There are no barriers in supporting residents who are admitted to the facility who identify as Māori. The Māori cultural policy states all values and beliefs are acknowledged with the support of the Te Whare Tapa Wha model and would then be integrated into a resident’s long-term care plans with input from cultural advisers within the local community as required. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. |
| 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 | Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident’s personal preferences, required interventions and special needs were included in care plans reviewed, for example, spiritual beliefs. The resident satisfaction survey confirmed that individual needs are being met. Family interviewed who had relatives in the dementia service reconfirmed that ethnic, cultural, spiritual values and beliefs were met. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses and enrolled nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and staff were responsive to medical requests.  Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. Policies and procedures are consistently reviewed and the facility manager approves all documents prior to implementation.  Other examples of good practice observed during the audit included day to day discussions between staff, residents and relatives. One resident interviewed stated that staff ensure that her privacy is maintained at all times when providing support with daily activities of living. Staff were observed maintaining privacy. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, and were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.  Staff know how to access interpreter services through the Waikato district health board and the contact number was available. Staff interviewed stated that interpreter services were however rarely required due to all residents able to speak English and staff being able to provide interpretation as and when needed. The senior registered nurse interviewed stated that there was good communication with families/whānau and families interviewed confirmed this.  There are residents who have significant sensory impairments which is reflected on the long term care plans reviewed. The care plan review showed interventions and equipment was provided to promote ongoing independence, communication and support. For example, staff communicated with ‘yes, no’ questions, and use clear slow speech providing time for two residents identified as having hearing loss. Staff interviewed knew the residents well. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic/ business plan which is reviewed annually, outlines the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to the board of trustees contained extensive and detailed information, sufficient to monitor the organisations performance. This included the statistics and narrative analysis for incidents and accidents, infections, restraint, bed occupancy, staffing, financial performance, and any known emerging risks or issues.  The FM has extensive experience as a manager and registered nurse in aged care facilities but has not maintained a practicing certificate. This person has been in the role for 18 months and demonstrated knowledge of the sector, regulatory and reporting requirements. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The manager maintains knowledge of the sector and currency about business and clinical practices by attending DHB forums, gerontology conferences and through on line education which meets and exceeds the ARCC requirement of attending eight hours professional development annually.  The service holds agreements and contracts with Waikato DHB and the MoH to deliver care for older people assessed as requiring rest home, dementia, hospital (medical and geriatric), respite, long term support-chronic health conditions (LTS-CHC) and for young people with disabilities. On the days of audit 49 residents in total were receiving services. These were 16 hospital residents (which included one person with a disability under 65 years of age) 27 rest home residents (including one LTS-CHC person) and six resident’s in the dementia unit. There were no respite or palliative care residents. |
| 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 | When the facility manager is absent, the senior RN who is experienced in the sector and able to take responsibility carries out duties under delegated authority. During this person’s absence another senior RN steps up to oversee clinical service delivery. Staff reported that these arrangements work well. |
| 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 | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and accidents, infections, complaints, internal audit activities, regular resident, family and staff satisfaction surveys, and monitoring implementation of improvements to address any service shortfalls.  A range of meeting minutes reviewed, (for example, staff, RN, quality and health and safety meeting minutes) showed that essential information is presented. This includes the results of internal audits, trends in incidents and other quality data analysis, new service development or projects. Staff reported their involvement in quality and risk management activities through carrying out internal audits, discussions at meetings and other day to day communications.  Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey in November 2018 revealed a high level of satisfaction. There were no issues raised that required investigation.  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 are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The FM described processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and there is a nominated health and safety officer who reports on and oversees safe work practices. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated monthly by the senior RN who provides a statistical and narrative analysis report to the FM and the Board.  The FM described essential notification reporting requirements, including for pressure injuries. They advised there had been one section 31 notification about a missing resident made to the Ministry of Health and DHB since the previous audit. There have been no police investigations, coroner’s inquests, issues based audits or any public health notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | 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 practicing certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained.  Staff orientation includes all necessary components relevant to the role. Recently employed staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and an initial performance review after a three-month period.  Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. Of the 26 caregivers employed, 11 have completed the dementia unit standards (US 23920-23923) and 12 are progressing toward achievement. The RNs and two ENs are also enrolled to complete these. All other caregivers have achieved The Certificate in Health and Wellbeing to level 3. There are sufficient (five of seven) trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staffing levels are adjusted 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, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24 hour/seven days a week (24/7) RN coverage in the hospital. Only staff who have completed or are progressing educational achievements in dementia care (US 23920-23923) are rostered for duties in the secure unit. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | All necessary demographic, personal, clinical and health information was fully completed in the residents’ files sampled for review. The administrator maintains the resident register electronically. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents’ files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. |
| 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 | Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and GP for residents accessing respite care.  Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements. Resident agreements were provided and all were signed and dated in a timely manner, stored appropriately and confidentiality was respected. |
| 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 as appropriate. The service uses the ‘yellow envelope system’ to facilitate transfer of residents to and from acute care services. There is open communication between services, the resident, the family whānau and GP. The GP interviewed stated that a transfer to the relevant DHB is dependent on whether the resident requires primary, secondary or tertiary services due to the geographical location of this service. A transfer letter is always documented if referred by the GP or a transfer form if an acute admission. All referrals are documented in the progress records. The family/EPOA are kept well informed by the RN at these times. |
| 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. | FA | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using hard copy records was observed on the day of audit. The staff member 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. Competencies are completed annually.  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 on request with weekly checks and balances being verified.  Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Good prescribing practices noted included 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 consistently recorded on the medicine chart. Standing orders are not used.  There was only one resident who was self-administering eye drops at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.  There is an implemented process for comprehensive analysis of any medication errors. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by one of two cooks and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years, dated 18 October 2017. Recommendations made at that time have been implemented.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service has a food control plan and this was audited by the Hauraki District Council on the 23 May 2019 and expiry will be 23 May 2020 as displayed. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All cooks and kitchen assistants have completed safe food handling.  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. There are two main cooks who cover the week and are supported by kitchen hands. All meals are prepared on site and served directly to the residents in the main dining room. The food is delivered to the dementia service and served up by the staff from the kitchenette available.  Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| 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 | If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement related to when a resident’s placement can be terminated. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, nutritional screening and depression scale and challenging behaviour, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments except for four which are overdue and six are due in the next month. There are five registered nurses (two are currently on leave) who are competent to complete the required assessments. 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 | Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the momentum care plans reviewed.  Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals’ notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Examples of short term care plans were observed such as for pyrexia, wound care and/or urinary tract infection (UTI). Residents and families reported participation in the development and ongoing evaluation of care plans. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner and that medical orders are followed with satisfactory care provided. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by a diversional therapist (DT). The DT has recently changed her hours of employment from Monday to Friday to three days a week Tuesday, Wednesday and Thursday. Currently the DT is the only activities person. A casual member of staff is able to provide cover until another activities staff member is employed. Volunteers regularly support the activities provided to residents. One family member interviewed is orientating to undertake the van outings in the community with assistance of staff.  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 their formal six- monthly care plan review.  Activities reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. Residents interviewed confirmed they find the programme very interactive and fun also stating that they are supported in individual specific activities of interest they have.  Staff/volunteers at the facility support the residents in the weekends and in the dementia service during the week days when the DT is not available. Residents in the rest home and hospital services are supported to participate in the weekly Wednesday van outings into the community and the dementia unit residents go out on a Friday afternoon. The activities programme is planned monthly but displayed weekly in all service areas. The residents are provided with a copy for their individual rooms. A church service is held every Sunday. Birthdays and special events are celebrated.  The activities for residents from the secure dementia unit are specifically planned to meet the needs and abilities of the six residents living there. There is a 24 hour activities programme in the dementia service which is clearly displayed for family and staff to view. All residents that present with behaviours that are challenging have had a 24-hour activity chart developed as a result of ongoing assessments, monitoring and evaluation to support all staff to be aware of activities and/or interventions that may reduce and minimise the challenging behaviour of the resident at that time. Weekly activities evaluations are maintained.  The facility has three resident cats, goldfish and budgies. A volunteer pet group visit regularly as many residents are from rural lifestyles. The residents are encouraged to continue to look after the pets with guidance from staff. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN or senior registered nurse.  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. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds, weight loss and trialling of restraint. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.3.9: 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 | Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a ‘house doctor’, residents may choose to use another medical practitioner of their choice. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents’ files, including to a speech language therapist, physiotherapist, diabetic or wound nurse specialists and dietitian. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate. |
| 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. Cleaning, laundry and kitchen staff have completed training in safe chemical handling. There is an improvement required with regard to labelling of chemicals in standard 1.4.6. An external company is contracted to supply and manage all chemicals and cleaning products and they provide ongoing support and training for staff. 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 which staff were observed using. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness (expiry date 17 March 2020) is publicly displayed.  Appropriate systems are in place to ensure the residents’ physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, 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.  External areas are safely maintained and are appropriate to the resident groups and setting.  Residents confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment. |
| 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 more than adequate numbers of accessible bathroom and toilet facilities throughout the facility, including designated staff and visitor toilets. Two of the rest home bedrooms have full ensuite bathrooms and the majority of hospital bedrooms share an ensuite bathroom between two rooms.  Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence. |
| 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 one double bedroom and all other bedrooms are single accommodation. Approval from the two female residents who share a bedroom has been obtained. Rooms are personalised with furnishings, photos and other personal items displayed.  There is room to store mobility aids, wheel chairs and mobility scooters. Staff and residents reported the adequacy of bedrooms. |
| 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 are available for residents to engage in activities. The main dining and lounge areas have been recently refurbished. The area is spacious and within easy walking distance to residents’ rooms. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents’ needs. |
| 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. | PA Low | Laundry is undertaken on site in a dedicated laundry. The laundry staff interviewed demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.  There is a small designated cleaning team who have attended training in safe chemical cleaning as confirmed by interview and review of training records. Chemicals and the cleaning trolleys were stored in a lockable cupboard when not in use. An improvement is required with regards to the decanting of cleaning products in to appropriately labelled containers.  Cleaning and laundry processes are monitored through the internal audit programme. |
| 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 their preparation for disasters and 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 in September 2016. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 12 June 2019. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  The onsite fire suppression systems are checked monthly by an appropriately qualified company.  Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ’s were sighted and meet the requirements for 50 residents and the Ministry of Civil Defence and Emergency Management recommendations for the region. The emergency lighting system was being regularly tested by maintenance staff.  The call bell system was functioning on audit day and residents and families reported staff respond promptly to call bells.  Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time and a security company checks the premises at night. There have been no security incidents. |
| 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 | All residents’ rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and doors. Heating is provided by electricity in residents’ rooms and in the communal areas. Areas were warm and well ventilated throughout the audit. Residents and families confirmed the facilities are maintained at a comfortable temperature.  There is a designated smoking area for the sole resident who smokes and the organisational smoke free workplace policy is known of and adhered to by staff. |
| 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 | Hetherington House implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the GPs, the senior registered nurse and a contracted infection control advisor as required. The infection control programme and manual are reviewed annually. A contracted infection control advisory service manual used by the service is reviewed annually and is a valuable resource manual for all staff. The programme is appropriate to the size and scope of the services provided.  A registered nurse is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the senior registered nurse and the facility manager and tabled at the quality/risk committee meeting. This committee includes the senior registered nurse, household staff and care staff.  Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities. |
| 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 coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this role since the beginning of 2019. The senior registered nurse interviewed stated that she will support the ICC coordinator as she transitions into this new role. Both the senior registered nurse and ICC coordinator have undertaken training in infection prevention and control as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The ICC has access to residents’ records and diagnostic results to ensure timely treatment and resolution of any infections.  The ICC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection. The facility has infection outbreak kits readily available and these are checked monthly. |
| 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 reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in February 2019 and included appropriate referencing. The reference manuals are reviewed annually by the contracted service provider.  Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified RNs, and the ICC. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred when there was an increase in urinary tract infections in November 2018 and education was provided at the staff meetings as part of a corrective action. Staff that are unable to attend staff meetings and/or teaching sessions are required to read the minutes of the meetings and education material provided and sign in acknowledgement that they have done so.  Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during hot weather. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The ICC reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the ICC and reported to the facility manager, quality team and all staff at the facility.  Residents’ files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Infection rates are low for the size and nature of the services provided.  The clinical services manager interviewed stated the facility has had no infectious outbreaks in the last 12 months. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice and her/his role and responsibilities.  On the day of audit, four residents were using restraints and three residents were using enablers, which were the least restrictive option and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.  Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint approval group is responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint review reports, residents’ files and interview with the restraint coordinator that there are clear lines of accountability that all restraints have been approved, and the overall use of restraints is being monitored and analysed.  Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Assessments for the use of restraint were documented and included all requirements of this Standard. The restraint coordinator undertakes the initial assessment with involvement and input from the resident’s family/whānau/EPOA. The restraint coordinator demonstrated good knowledge of the process and a family member confirmed their involvement. The general practitioner confirmed that they were involved and informed about the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident’s safety and security. Completed assessments were sighted in the records of all the residents who were using a restraint. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members, for example, the use of sensor mats, low-low beds and ‘fall out’ mattresses. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected. The restraint register is kept updated and includes details about the resident, the type of restraint in use, the date of approval and commencement and review periods. The register logs the reasons for ceasing use of restraint. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Review of residents’ files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the monthly quality committee meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation was completed as required. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | Review of the monthly quality meeting minutes and audits of restraint practice confirmed these as a comprehensive quality review of all restraint use. This meets the requirements of this Standard. Trends in restraint use are reported to the board, and at the monthly quality and staff meetings. The restraint coordinator considers the overall use and type of restraint in place, whether all alternatives to restraint had been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback received from other parties. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the Snr RN/coordinator confirmed that the use of restraint is kept to a minimum. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Low | There is a schedule developed and implemented for completing the interRAI assessments and for updating the care plans six monthly. Four interRAI assessments were overdue at the end of July. | Four interRAI assessments were overdue at the end of July. | Ensure that all interRAI assessments are kept up to date.  90 days |
| Criterion 1.4.6.2  The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness. | PA Low | Three cleaning products (a urine digester, ‘Powersan’ a cream abrasive and a water and vinegar solution) were being decanted in to containers that had been used for other products. Although the content of the containers was clearly marked with permanent ink, this is not consistent with safe chemical handling procedures.  The internal audit processes for monitoring safe and effective cleaning practices had not identified this as an issue. | Not all cleaning products were being stored in appropriately marked containers.  This had not been identified in the most recent cleaning audit (December 2018) and there was no evidence that the cleaning audit due in March this year had occurred. | Ensure that all cleaning products are being stored in appropriately marked containers.  Ensure that monitoring of cleaning processes occurs as scheduled.  60 days |

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

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

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

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

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End of the report.