

St Patricks Limited - St Patricks Home and Hospital

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	St Patricks Limited
Premises audited:	St Patricks Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 February 2020 End date: 26 February 2020
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:	50

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
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

St Patricks Home and Hospital provides rest home and hospital level of care for up to 60 residents. There were 50 residents on the day of audit.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The manager is a registered nurse who has been in the role for three and a half years and works full time. She is supported by a clinical manager with experience in aged care, who has been in the role for three years.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided at St Patricks Home and Hospital.

Eight of the ten shortfalls identified as part of the previous audit have been addressed. These were around; admission agreements, RN oversight, kitchen services, progress notes, assessments, acute changes, care plan evaluations, and laundry services.

Further improvements required around care plan documentation and timeframes. This audit also identified improvements required around the quality system.

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.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a business plan with goals for the service that has been regularly reviewed. St Patricks Home and Hospital has a documented quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activities' coordinator. All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives reported satisfaction with the food service.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building holds a current warrant of fitness. External areas are safe and well maintained. Cleaning and laundry services are well monitored through the internal auditing system.

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.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were no residents using restraint and one resident with an enabler. Restraint management processes are adhered to.

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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	16	0	1	2	0	0
Criteria	0	43	0	1	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy describes the management of the complaints process. Complaints forms are available at reception. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. All staff interviewed, including the manager, the clinical manager, four caregivers, one registered nurse (RN), two kitchen staff, the administrator and two activity staff, demonstrated an understanding of the complaints process.</p> <p>There is a complaint register. Five complaints have been lodged in 2019 and none for 2020 year to date. Verbal and written complaints are documented. All five complaints had a noted investigation, timelines determined by HDC were met, and corrective actions (where indicated) were actioned. Four complaints were documented as resolved with one ongoing complaint. The complaints included one through the DHB and one through the Ministry of Health, both of which have been closed.</p> <p>Complaints are linked to the quality and risk management system. Discussions with residents and relatives confirmed that any issues are addressed and that they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication Service providers</p>	<p>FA</p>	<p>Four residents (two hospital and two rest home) interviewed, with the assistance of an interpreter stated they were welcomed on entry and were given time and explanation about the services. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms selected for review indicated that family were informed. Five families (three hospital and two rest home) interviewed with the assistance of an interpreter when needed, confirmed they are notified of any changes in their family member's health status. Interpreter services are available if needed. Staff and family are utilised in the first instance.</p> <p>The service has a variety of information and communication strategies with families and residents such a newsletters and signage all of which are in English and Mandarin. The admission agreements also have a Mandarin version. Five admission agreements reviewed had all been signed. This is an improvement from the previous audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>St Patricks Home and Hospital is owned and operated by group which include the owner / manager, the clinical manager and a director. The service provides care for up to 60 residents (including eight dual-purpose beds). On the day of audit, there were 13 rest home residents and 37 hospital care residents. All residents were under the age-related residential care services agreement.</p> <p>The service has a business plan, which is reviewed annually. The business plan identifies the purpose, values and scope of the business. The service has quality goals, which have been reviewed regularly through facility meetings.</p> <p>The owner / manager has experience in health management and has been in the role for three and a half years. The manager is supported by an experienced clinical manager (registered nurse and co-owner), with a background in aged care. A third owner, (the director) maintains close links with the service and is in communication or visits daily.</p> <p>The owner / manager and clinical manager have has completed at least eight hours of professional development.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>PA Low</p>	<p>A quality and risk management programme developed by an external consultant is in place. Interviews with the managers and staff confirmed their understanding of the quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed.</p> <p>The service holds a series of meetings including monthly staff meetings, three monthly infection control meetings and two monthly clinically focussed meetings. Staff communication is also maintained through closed chat groups to staff. The chat groups include; all staff, care team, RNs and family group.</p> <p>Data collected such as; falls, incidents and accidents, wounds, skin tears, pressure injuries and complaints are</p>

<p>improvement principles.</p>		<p>collated and analysed, but results are not consistently documented as communicated to staff. Action plans are implemented where trends or spike indicate that an issue is occurring. An internal audit programme is in place, corrective action plans were documented for areas of noncompliance, but not always reported to staff.</p> <p>Family and resident meetings are held. The meetings are in Mandarin and in English and there are two sets of meeting minutes (one English and one Mandarin).</p> <p>There is a health and safety team that meet quarterly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed.</p> <p>Strategies are implemented to reduce the number of falls. This includes (but is not limited to) ensuring call bells are placed within reach, the use of sensor mats, encouraging participation in activities, and physiotherapy. Caregiver interviews confirmed that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</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>There is an accident and incident reporting policy. Adverse events are investigated by the clinical manager and/or registered nursing staff, evidenced in all ten accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow-up of residents is conducted by a registered nurse. Unwitnessed falls include neurological observations.</p> <p>Discussion with the care home manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications. One section 31 has been reported for a stage three pressure injury.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	<p>FA</p>	<p>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs, two healthcare assistants, and the clinical manager). Staff files included an application form and reference checks, a signed contract, a job description relevant to the role the staff member is in and completed induction checklists. All files reviewed included annual performance appraisals.</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is an annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. There was evidence of training following complaints and audits, including palliative care updates.</p> <p>There are eight registered nurses including the manager and clinical manager; three have completed interRAI training. Clinical staff complete competencies relevant to their role. The RNs and clinical manager have access to external 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>A staff rationale and skill mix policy is in place. Sufficient staff are rostered on to manage the care requirements of the residents. The manager and clinical manager are registered nurses.</p> <p>The facility covers two floors as it is built on the side of a hill. The care floor is accessed from the front of the building (the main care floor). There are 41 residents are on the main care floor.</p> <p>There were three hospital level residents and six rest home the lower floor. The lower floor rooms all open to the garden. There is a lift and stairs between floors and covered walkways to all rooms.</p> <p>For all residents (13 rest home and 37 hospital) over two floors the staffing included;</p> <p>One RN each shift, three full shift healthcare assistants on the AM shift, four on the PM shift and three at night.</p> <p>Healthcare assistants are allocated to the upstairs and downstairs residents and RNs maintain oversight. At night, one healthcare assistant undertakes the laundry. This is on the same level as the lower floor.</p> <p>The service maintains oversight of the newer registered nurses. The clinical manager and an RN were able to discuss how the service supported newer registered nurses into their role. This included an orientation programme, ongoing training and ensuring that all new registered nurses (including new graduates) work on day shift until the clinical manager and new nurse are fully orientated into the role. The RN interviewed stated that the senior staff are always available for advice and on call.</p> <p>The GP interviewed stated that the clinical care was very good and praised the high level of clinical competence. One hospital level resident on the lower floor stated that they feel supported by the staff and has chosen the room where they are very happy.</p> <p>The previous shortfall around RN and healthcare oversight of the residents on the lower floor and new graduate support is an improvement from the previous audit.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents</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>FA</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. The service utilises roll packs. The service uses an electronic medication management system.</p> <p>All medications were securely and appropriately stored. Registered nurses or senior HCAs, who have passed their competency, administer medications. Medication competencies are updated annually. Medication charts have photo IDs. There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy.</p> <p>Ten electronic medication charts and signing charts were reviewed. All medication signing sheets aligned with the medication charts.</p> <p>Electronic medication profiles reviewed were legible, up-to-date and reviewed at least three-monthly by the GP. All medication charts reviewed have 'as needed' medications prescribed with an individualised indication for use. The medication round observed was completed correctly. The medication fridge has temperatures recorded daily and these are within acceptable ranges and room temperature recording has commenced (within range on day of audit). Medication management audits are completed as part of the internal audit system.</p>
<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>	<p>FA</p>	<p>There is a fully equipped commercial kitchen, which is located centrally in the facility. The majority of food is prepared and cooked on site. All kitchen staff have completed food safety training. The menu has been approved by a dietitian and includes a choice of European and Chinese style meals for each meal. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served directly from the kitchen to residents in the dining room or to their rooms as required. All food in the freezer and fridge was labelled and dated. The food control plan has been approved until December 2020. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for. Alternative meals can be accommodated if needed. Residents' weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs,</p>	<p>FA</p>	<p>Files reviewed across the rest home and hospital identified that risk assessments have been fully completed on admission and reviewed six-monthly as part of the evaluation (link 1.3.3.3). InterRAI assessments reflected resident need. Additional assessments for management of behaviour, pain, wound care and enablers were appropriately completed according to need. For the resident files reviewed, formal assessments and risk assessments were in</p>

support requirements, and preferences are gathered and recorded in a timely manner.		place and reflected into care plans. InterRAI assessments, fully completing initial assessments, and evaluation of care plans towards stated goals are an improvement from the previous audit.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	Care plans reviewed demonstrated service integration and input from allied health. All care plans (including short and long-term care plans) reviewed, included interventions to address all of the resident needs. Care plans reflected the interRAI and service specific assessments. Care plans were documented well for a resident with dialysis, a diabetic, wound care and weight loss. Care plans linking to interRAI and service assessments are an improvement from the previous audit. Two care plans did not include specific care needs, including one for behaviours that challenge and one for a supra pubic catheter, specific interventions are a continued shortfall from the previous audit.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Interview with one GP evidenced that care provided is of a high standard and GPs are kept informed. Family members interviewed stated care and support is good and that they are involved in the care planning. Healthcare assistants and RNs interviewed stated there is adequate equipment provided, including continence and wound care supplies. Wound assessment, wound management and evaluation forms are in place. There were three wounds being managed (one healed PI, one donor site and one grazes). Wound management and monitoring occurred as planned. All have appropriate wound care management plans documented and provided, including pressure relieving equipment. Access to specialist advice and support is available as needed. Care plans document allied health input. A sample of wounds reviewed in detail included a link to STCPs and LTCPs. There is wound care specialist input where needed. Physiotherapy and dietitian input are provided for residents. Monitoring charts were well utilised and examples sighted included (but not limited to) weight and vital signs, blood glucose, pain, food and fluid, turning charts, and enabler monitoring. Short-term care plans were in use for changes in health status and signed off as resolved or transferred to the long-term care plan, this is an improvement from the previous audit. There was evidence of service integration with documented input from a range of specialist care professionals.
Standard 1.3.7: Planned Activities Where specified as	FA	The service employs an activity coordinator who is currently completing a qualification in diversional therapy. She is supported by a diversional therapist from a sister home. Each resident has an individual activities programme, which is reviewed when their plan of care is reviewed and as

<p>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>part of their interRAI assessments.</p> <p>Group activities are provided five days a week and published both in English and Mandarin. The group programme covers physical, cognitive, social and spiritual needs. There are regular visiting entertainers and community groups.</p> <p>The service arranges activities in two separate lounges; one is mainly for mandarin speakers and Chinese activities and one (the main lounge) is usually English. All residents can attend any lounge. There are regular van trips for shopping and outings.</p> <p>Resident meetings allow feedback and activities are adapted according to feedback. Families and residents were very complimentary regarding activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed had been evaluated by registered nurses six-monthly, or when changes to care occurred and document progress of achievement towards the desired goal or outcome, this is an improvement from the previous audit. Activity plan evaluations were completed six monthly. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they are invited to attend the care plan reviews and GP visits.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness, which expires 20 October 2020. The facility has a lift between the ground floor and first floor level. There are hospital and rest home rooms located on the ground floor. The lift is large enough to allow residents to be transported by wheelchair or ambulance trolley. There are proactive and reactive maintenance management plans in place. The grounds and gardens are well maintained. Contracted providers test equipment. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services</p>	<p>FA</p>	<p>The cleaners have access to the appropriate equipment and chemicals. Cleaning equipment and cleaning chemicals are stored securely when not in use. All laundry is completed on site. There are two entry/exit doors (clean and dirty) with designated clean/dirty areas. This is an improvement from the previous audit. The internal auditing system and the satisfaction surveys monitor cleaning and laundry services. Cleaning and laundry staff receive training at orientation and through the in-service programme. There are policies in place to guide practice. Residents and family members interviewed expressed satisfaction with the laundry and cleaning services provided.</p>

appropriate to the setting in which the service is being provided.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (clinical manager) uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>A monthly log of infections and short-term care plans are completed for all resident infections. Infection control data is collated monthly and reported at the three-monthly infection control meetings and monthly staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices, identifying trends and corrective actions/quality initiatives. Infection control data is on display for staff. The infection control programme is linked with the quality management programme. Benchmarking occurs through an external consultant.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraints and one resident using an enabler. The resident with and enabler file was reviewed. There was an assessment and consent for bed rails signed by the resident. The care plan included the enabler and monitoring was documented as charted.</p> <p>Staff interviews and staff records evidenced guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education including assessing staff competency on RMSP/enablers has been provided.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	The documented quality and risk programme has been implemented. The service collates information and data and makes service charges as a result of the collated data. The data and resulting changes are not documented as reported to staff. Staff interviewed stated that they are very well informed. Survey results have not all been communicated.	<p>(i). Meeting minutes do not reflect that all quality information is communicated to staff including; incidents and accidents, complaints, and internal audit results.</p> <p>(ii). The annual family/resident survey results have not been documented as communicated to family and residents.</p>	<p>(i). Ensure that quality information is documented as communicated to staff residents.</p> <p>(ii). Ensure that the family/resident survey results are communicated to family and residents</p>

				90 days
<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>All residents have an initial assessment on admission to services. A long-term care plan was documented within 21 days for all new residents. The initial interRAI was not always within timeframes for two of two new residents</p>	<p>One rest home and one hospital level resident's initial interRAI were not within timeframes.</p>	<p>Ensure that the timeframes for interRAI initial assessments are within 21 days.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Care plans reflect assessments and are overall resident and goal focused. However, not all resident needs have been fully addressed.</p>	<p>One hospital resident with a supra pubic catheter did not have care needs fully addressed in the care pa.</p> <p>One rest home resident with behaviours that challenge had this issue documented in the care plan but no interventions to manage.</p>	<p>Ensure that all care needs are fully documented in the care plan.</p> <p>60 days</p>

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.

No data to display

End of the report.