

Arbor House Trust

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:	Arbor House Trust
Premises audited:	Arbor House Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 December 2014 End date: 9 December 2014
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:	21

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

Arbor House rest home and hospital is owned and operated by a community trust. The clinical nurse manager reports to the board of directors. The service has recently undergone a change in management and the organisation is in the process of reviewing all its systems and processes. On the day of audit there were 21 residents (11 rest home and 10 hospital). Family and residents interviewed all spoke positively about the care and support provided.

Three of the ten previous shortfalls have been addressed around code of rights information, aspects of care planning and aspects of medication.

Further improvements are required by the service around incidents and accidents documentation and follow up, aspects of the quality programme, temperature monitoring, and restraint documentation.

This audit also identified improvements required in relation to the complaints process, aspects of human resources, staff orientation and education, documentation of assessments and care plans, activity plans, safe storage of chemicals and aspects of infection surveillance.

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

The service has an implemented open disclosure policy. There is a complaints policy and an incident/accident reporting policy. Information on how to make a complaint and the complaints process were included in the admission booklet and displayed throughout the facility.

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 medium or high risk and/or unattained and of low risk.
---	--	--

The clinical nurse manager provides oversight of the service with a team of registered nurses. There is a quality and risk management system in place. The service collects data relating to adverse, unplanned, and untoward events. This includes the collection of incident and accident and near miss information.

Human resource policies are in place including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

There is an implemented orientation programme that provides new staff with relevant information for safe work practice and an in-service education programme that exceeds eight hours annually for all staff.

Continuum of service delivery

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

There are policies and procedures around care planning and registered nurses are responsible for all care planning and documentation. There is an activities programme.

Registered nurses are responsible for medication administration. Medications have been reviewed by the residents' general practitioner at least three monthly. Individual resident's medication charts were sighted.

The menu has been designed by the cook. Residents have had a nutritional profile developed on admission. All residents interviewed stated that the food was good.

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.
--	--	---

There is a current building warrant of fitness which expires 30 June 2015.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

There is a restraint minimisation and safe practice policy that includes comprehensive restraint procedures. There were two residents utilising restraint and one resident with an identified enabler. Staff have been trained in restraint minimisation and restraint competencies have been completed regularly.

Infection prevention and control

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

Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

All surveillance activities are the responsibility of the infection control coordinator (RN) with support from the manager. There is an infection register in which all infections are documented monthly.

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	4	0	8	7	0	0
Criteria	0	24	0	12	8	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>PA Low</p>	<p>The service has complaint management policies and procedures that are aligned with Code 10 of the Code of Rights. A complaints register/folder is in place that documents complaints. A complaints folder has been maintained, however there is no documentation related to each complaint or sign off of the complaint apart from the latest complaint (August 2014) which has been dealt with by the new manager.</p> <p>D13.3h. A complaints procedure is provided to residents and their family within the information pack at entry.</p> <p>Complaint forms are available at the entrance to the building. Staff were aware of the complaints process and to whom they should direct complaints. The complaint process is in a format that is readily understood and accessible to residents/family.</p> <p>Seven rest home and one hospital resident and two family members interviewed confirm they were aware of the complaints process and they would make a complaint to the manager. The previous audit identified an improvement required around ensuring that advocacy and Code of Rights information is included in replies to complaints. This was evidenced in the most recent complaint, therefore this previous shortfall has been addressed.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>PA Low</p>	<p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Arbor House information booklet is provided to residents on entry and this includes information around rights, complaints, abuse and neglect etc.</p> <p>D16.1b.ii The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p> <p>D16.4b Two relatives interviewed (one rest home and one hospital) stated that they were always informed when their family members health status changes, however incident forms and associated progress notes reviewed in November 2014 did not evidence that family have been informed.</p> <p>D11.3 The information pack is available in large print and advised that this can be read to residents. The service has policies and procedures available for access to interpreter services noting that there are no residents requiring interpreting services.</p> <p>There is an open disclosure policy, a complaints policy and an incident and accident policy and staff have had training around the code of rights June 2013. Eight residents (seven rest home and one hospital) interviewed and two family members interviewed stated they were welcomed on entry and were given time and explanation about services and procedures. Two family members interviewed stated they were informed of changes in health status.</p> <p>Residents have meetings with an independent advocate who visits one-two monthly (# link 1.2.3.6).</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>Arbor House rest home and hospital is owned and operated by a community trust. This 'not for profit' trust is led by a board of directors. The service has appointed a new manager (registered nurse) in May 2014 who has a background in emergency nursing, patient services management and has been the general manager for clinical services for a district health board. The manager reports monthly to the community trust board.</p> <p>The service provides rest home or hospital level care across 26 beds. On the day of audit there were 21 residents (11 rest home and 10 hospital).</p> <p>There is a documented mission statement and philosophy. The business plan and</p>

		<p>quality and risk plan August 2013 remains current. The manager has identified service goals since her appointment which are reported to the board.</p> <p>The clinical nurse manager has maintained professional development activities related to managing a rest home and hospital. The manager attends two monthly provider meetings and has formed professional relationships with another aged care provider to share resources and training for staff.</p> <p>Staff interviewed stated that they receive good support from the manager who is able to provide advice at any time.</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 improvement principles.</p>	<p>PA Moderate</p>	<p>Arbor House has a risk management plan dated August 2013. The plan includes clinical risks as well as business risks. There is a quality plan August 2013. The manager has implemented service goals.</p> <p>There is a documented audit schedule, however there have been no audits completed since June 2014. There have been no corrective action plans generated as all audits completed have reached full compliance. This was a previous audit shortfall that still requires improvement.</p> <p>There is a meeting schedule, however meetings have not been completed as per the schedule. There is no documented evidence that quality outcomes including incidents and accidents, complaints and audits are reported to the two monthly staff meetings, monthly clinical meetings or quality meetings. This was a previous audit shortfall that still requires improvement. There is no documented evidence that quality data is collated and evaluated and used for quality improvement.</p> <p>There have been no residents meetings completed as per the meeting schedule and no satisfaction survey completed 2014. There is a resident's advocate who visits and speaks with the resident every two months.</p> <p>There is a document control system. All policies include the date the policy was last reviewed and a review date. Not all policies have been reviewed as per the schedule review date. The manager is currently implementing new policies purchased from an external aged care policy expert.</p> <p>The service has policies, procedures, processes and systems that support the provision of clinical care and support including care planning and this is currently being reviewed with the implementation of new policies and procedures form and external aged care expert.</p>

		<p>There are implemented health and safety policies that include hazard identification. Health and safety has been included in the staff meeting 1 October 2014, which included monitoring of hazards, and risks.</p> <p>Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.</p> <p>There are infection control policies and procedure, a restraint policy and health and safety policies and procedures which are currently being reviewed.</p> <p>D19.2g: Falls prevention strategies are in place that include sensor mats for relevant residents, increased supervision if required for a resident identified as a high falls risk and the identification of interventions on a case by case basis to minimise future falls.</p>
<p>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.</p>	<p>PA Moderate</p>	<p>D19.3b; There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p> <p>Incidents/accidents and near misses have been individually investigated and a log of incidents were completed monthly (# link 1.2.3.6).</p> <p>D19.3c Discussions with the manager and registered nurses confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>Ten incident forms were reviewed for November. There is no evidence of incident forms being signed off/reviewed by the registered nurse or changes to the long term care plan or short term care plan being initiated where required. This was a previous audit finding that still requires improvement.</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Arbor House has a total of 34 staff. There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six staff files reviewed included two registered nurse, two caregivers, one cook and one activities coordinator. Improvement is required around human resource management.</p> <p>A copy of practising certificates including registered nurses (RNs), pharmacists, the</p>

		<p>podiatrist and general practitioners (GPs) has been maintained.</p> <p>An orientation programme has been implemented, however there was no documented evidence of orientation in all six files reviewed. There has been a low turnover of staff and a new staff member is always rostered on with another staff member.</p> <p>In-service education has been conducted during 2014 and has covered a range of topics. There is evidence of an education plan 2013 documented. The training programme exceeds eight hours annually. The service introduced on-line staff training and there is documented evidence of on-line training occurring. Three registered nurses (including the manager) have completed InterRAI training.</p> <p>The new manager is currently reviewing all staff files, orientation processes and training schedules and has engaged clinical nurse specialists to complete education for the staff (wound care, continence and end of life care). The manager is working on an education plan for 2015. The service links to the DHB for RN training.</p> <p>The kitchen staff last completed a food safety course in 2007.</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>Arbor House has a documented rationale for determining staffing levels and skill mixes. There is a staff skill mix policy and staffing policy. The factors that are taken into account are detailed in these policies. The policies also refer to Ministry of health guidelines for safe staffing levels. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>A review of the roster and discussion with two RNs and three caregivers evidences that the service ensures that there are appropriate staff, including an RN and a first aider on each shift to safely provide care for the current occupancy of 21 residents. Staff turnover is low. The service does not use agency staff and all leave is covered in the rosters reviewed.</p> <p>There is on-call systems in place.</p> <p>Seven rest home and one hospital resident and two family members (one rest home and one hospital) interviewed statde that there were sufficient staff on duty at all times.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Medications are administered by registered nurses. All medications are stored in a locked cabinet inside the locked medication room.</p> <p>Medication reconciliation has been completed on admission by a registered nurse. Medication signing sheets have been completed by the RNs administering medications. This was a previous audit finding that has now been addressed.</p> <p>There are currently no residents' who are self-medicating. There was a previous audit finding around competency assessment for self-medicating residents. This was unable to be confirmed as being addressed as there were no residents self-administering medications.</p> <p>A number of improvements are required around medication practices and documentation.</p> <p>D16.5 Ten medication charts reviewed identified that the general practitioner had reviewed the resident three monthly and the medication chart was signed and dated.</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>PA Low</p>	<p>The service has a workable well equipped kitchen. The menus are overseen and audited by an external registered dietitian (2013) the day to day management of the meals is by the cook. Advice can be sourced from the dietitian at any time. There is a winter and summer menu.</p> <p>All meals are cooked in the main kitchen and served from the kitchen directly to the residents in the main dining room. Caregivers were sighted on the day of the audit assisting with food service and contributing to ensuring the needs of the residents were met. On interview the cook was able to speak to ensuring these requirements were met. The cook and kitchen assistant had completed a food handling safety course in 2007 (link 1.2.7.5).</p> <p>There was documented evidence that the kitchen fridge, food and freezer temperatures were monitored and documented by the cook for the last two days only. Recording of hot food temperatures was a previous audit finding that still requires improvement. The cook stated that changes to residents' dietary needs are communicated to the kitchen by the registered nurses verbally. Interviews with eight residents and two relatives report that the food is very good.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>Six resident files were reviewed (three rest home and three hospital).</p> <p>Four residents interviewed reported their needs were being appropriately met and found the staff friendly and helpful. The previous audit identified a practice of 'syringing food'. This has now been addressed and has ceased.</p> <p>D18.3 and 4 Dressing supplies are available and a treatment room is stocked for use.</p> <p>Continence products are available and resident files include a urinary continence assessment and continence products identified for use.</p> <p>Wound assessment and wound management plans/skin tear plans were in place for two wounds. This was a previous audit finding that has now been addressed. The GP was not available for interview.</p> <p>Monitoring charts were not all up to date.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>There is one diversional therapist at Arbor House, who has worked there for two years. There is also a part-time activity assistant. The activities assistant works three half days a week. The service continues to provide a range of activities for the residents the rest home and hospital care, seven days a week. The activities assistant stated that there was a level of flexibility to respond to what the residents' wanted to do. At the time of audit there was a game of housie in progress in the lounge.</p> <p>Files reviewed included activities section in the resident file that includes and activities assessment, life experiences' care and an incomplete activities care plan.</p> <p>The activities programme supports resident's activity and is sufficiently comprehensive to meet the needs of residents. Eight residents stated the activities programme is enjoyable and interesting. Van outings are provided for those able to participate.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>There is a documented process for the evaluation and review of care plans on a six monthly or as needed basis. Registered nurses interviewed were aware of the review process (# link 1.2.4.3). However reviews of long term care plans are not current (link 1.3.3.3). There were examples where care plans had been updated</p>

		when needs change. (also link 1.3.6.1 and 1.2.4.3).
<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>	FA	There is a current building warrant of fitness which expires 30 June 2015
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	PA Low	Cleaning policy and procedures, and laundry policy and procedures are available. Product user charts, chemical safety data sheets for all chemicals used in the facilities. There are policies and procedures for the safe storage and use of chemicals / poisons. Chemicals were not always secure.
<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>	PA Moderate	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data collection, collation and analysis (to identify areas for improvement or corrective action requirements) have been the responsibility of the registered nurse since September 2013. Individual infection forms have not been completed for each resident with an identified infection and there was no evidence that infection data has been documented since July 2014. Detailed information on the type of infections, treatment, duration of treatment and its effectiveness has been recorded prior to July 2014. Resident's infection trends/patterns have been identified and recorded prior to July 2014. There was no documented evidence that infection quality data is reported to staff at meetings (# link 1.2.3.6)</p> <p>The registered nurse confirmed that the GP, the laboratory, public health and infection control nurse at the hospital is available for consultation and support of infection control issues.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint Minimisation and safe practice policy & procedure that is appropriate to the service. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0.</p> <p>The service philosophy around restraint is that it is used as an intervention that requires a rationale and is regarded as a last intervention when all other</p>

		<p>interventions or calming/defusing strategies have not worked.</p> <p>There was one resident with an enabler in the form of bedsides and two residents with restraint in the form of bedsides. The assessment process ensures enablers are voluntary and the least restrictive option, however this has not been fully implemented (link 1.3.3.3).</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Moderate	<p>The previous audit identified that there was no documentation of restraint monitoring. A review of two residents with bedsides as restraint and one resident using bedsides as an enabler identified that there continues to be no documentation to support restraint or enabler monitoring.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	PA Low	<p>The previous audit identified that restraint evaluations had not been completed six monthly. There continues to be no documented evidence of evaluations for the three resident files reviewed.</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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	The service has complaint management policies and procedures that are aligned with Code 10 of the Code of Rights. A complaints register/folder is in place that documents complaints. A complaints folder has been maintained.	Not all complaints documented have documentation to evidence that the complaint has followed the process and has been signed off.	<p>Ensure that all complaints have documentation to support that each complaint has been dealt with and signed off.</p> <p>60 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	There is an open disclosure policy and two family members interviewed stated they were informed of changes in health status. Ten incident forms were reviewed for November. There is documented evidence that three of ten incidents included family notification.	Seven of ten incidents forms reviewed did not evidence that family were notified.	<p>Ensure that documentation reflects that family are notified of resident incidents unless requested otherwise.</p> <p>90 days</p>

<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>	<p>PA Low</p>	<p>There is a document control system. All policies include the date the policy was last reviewed and a review date. Not all policies have been reviewed as per the schedule review date. The manager is currently implementing new policies purchased from an external aged care policy expert.</p>	<p>A number of policies including but not limited to restraint (2007), challenging behaviour (2007) waste management (2010) and catheter care (2010) have no evidence of current review.</p>	<p>Ensure that all policies are reviewed according to the policy review date.</p> <p>90 days</p>
<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>	<p>PA Moderate</p>	<p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. There is an incident reporting policy. Accident/incident forms are commenced by caregivers and given to a registered nurse for follow up. All incident/accident forms are seen by a registered nurse and/or manager who completes any additional follow up. Infection data is collated.</p> <p>There is a quality plan August 2013. The registered nurse has been completing audits since September 2013. There is a documented audit schedule.</p> <p>There is a meeting schedule. Quality/staff meetings are scheduled two monthly. Registered nurses meetings are scheduled monthly (last minutes sighted 28 May 2014). There is a resident's advocate who visits and speaks with the resident</p>	<p>(i) There was no documented analysis of quality data including incidents and infections. (ii) A staff member undertaking internal audits did not fully understand the audit procedure and requirements and there have been no audits completed since June 2014. (iii) Meetings were not consistently held as per the schedule. (iv) There was no documented evidence that quality outcomes including incidents and accidents, complaints and audits were reported to the two monthly quality/ staff meetings or registered nurse meetings. (v) There was no documented evidence of residents meetings or resident satisfaction survey.</p>	<p>(i) Ensure that collation and analysis of quality data i.e. incident and accident reports and infection control occurs. (ii) Ensure that the quality programme is fully implemented and all audits are completed as per the audit schedule. (iii) Ensure that meetings are held as per planner to provide opportunities for discussion, monitoring and reporting on all quality activities. (iv) Ensure that residents meetings are held and that this is documented. (iv) Ensure that meeting minutes reflect discussion of quality outcomes. Ensure that a resident satisfaction survey is conducted.</p> <p>90 days</p>

		every two months.		
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	The registered nurse has been completing audits since September 2013. There is a documented audit schedule.	Internal audits reviewed did not identify action plans	<p>Ensure that audit action plans are generated as required.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Moderate	<p>There is an incident and accident policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p> <p>Incidents/accidents and near misses are investigated and a log of incidents occurs monthly</p>	(i) All ten incident forms did not evidence that the registered nurse had reviewed/signed off the incident. (ii) There was no documented evidence of the long term care plan having been updated or a short term care plan initiated for three residents with injuries.	<p>(i) Ensure that there is documented review of incident forms by the registered nurse. (ii) Ensure that the resident's long term care plan is updated with any health changes following incidents or short term care plans initiated.</p> <p>60 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>There are comprehensive human resources policies folder including recruitment, selection, orientation and staff training and development. Six staff files reviewed included two registered nurse, two caregivers, one cook and one activates coordinator</p>	(i) Four of six staff files reviewed did not have signed copies of job descriptions and one file did not have a current job description. (ii) Five files did not have annual staff appraisals completed.	<p>(i) Ensure that job descriptions are completed and signed for all staff. (ii) Ensure that all staff have current annual staff appraisals completed.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction</p>	PA Moderate	There is a documented orientation programme that could be described by staff.	There is no documented evidence that orientation has been completed in the six staff files	Ensure that all staff files evidence that orientations have been completed.

programme that covers the essential components of the service provided.			reviewed.	90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	The cook and kitchen assistant have not completed a food safety course refresher since 2007.	There was no documented education planner for 2014 or a current 2015 plan established. The cook and kitchen assistant have not completed a food safety course refresher since 2007.	<p>Ensure that there is an education plan for 2015 which includes compulsory topics.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	The general practitioner has documented a three monthly review of all medication charts. Medications are administered by RNs. The service internal audit includes the management and storage of medications.	(i) In the hospital level medication trolley there were two eye drops which had not been dated on opening. (ii) Seven as required medication prescriptions did not include indications for use. (iii) Controlled medications were only signed by one person on the medication chart. (iv) Antibiotics prescribed by the general practitioner and documented on the medication chart did not include a start or finish date. (v) Fridge temperatures were not recorded.	<p>(i) Ensure all eye drops are dated on opening. (ii) Ensure that 'as required' medication prescriptions include reason for administering. (iii) Ensure the registered nurse obtains a second signature from a medication competent staff member when administering controlled medications. (iv) Ensure the general practitioner includes a start and finish date for short course medications. (v) Ensure that medication fridge temperatures are recorded.</p> <p>30 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they</p>	PA Moderate	Registered nurses administer medications. The manager is medication competent.	Registered nurses (seven) did not have a current medication competency completed.	Ensure staff that administer medications complete a medication competency and that this is reviewed annually

manage.				7 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	The service requires that food and fridge temperature are recorded, however this has not been routinely completed.	Food and fridge temperature recordings have not consistently been recorded (evidenced for the last two days only).	<p>Ensure that food and fridge temperatures are consistently recorded and that this is documented.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Moderate	Arbor House Rest Home and Hospital is currently in the process of reviewing care plan documentation and timeframes. Staff were able to describe the current cares and that care plans were appropriate for the residents'.	(i) Six resident files did not include up to date assessments. One hospital resident on controlled medication analgesia had no pain assessment completed. Three resident files (two rest home and one hospital) did not include documented evidence of a nutritional assessment, while two nutritional assessments (one rest home and one hospital) had not been reviewed six monthly. (ii) One rest home resident file did not include a general practitioner admission visit within two working days. (iii) Two rest home resident files did not have a long term care plan in place, (iv) Four of four care plans (two rest home and two hospital) reviewed did not document family/ resident involvement with the care plan. (v) There was no assessment for the use of an enabler or for two residents with restraints.	<p>(i) Ensure all assessments are documented and reviewed in a timely manner including pain and nutrition. (ii) Ensure all residents are seen within two working days of admission. (iii) Ensure care plans are completed within three weeks of admission; (iv) Ensure there is documented evidence that family/resident are involved in the residents care plan as appropriate. (v) Ensure assessments are completed for residents utilising enablers and restraints.</p> <p>60 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>There is an appropriate care plan format with headings that reflect the holistic needs of both rest home and hospital level residents. Interview with caregivers evidences that they are aware of the needs of the residents and are knowledgeable about how to provide care.</p>	<p>(i)One hospital resident who is transferred using a sling hoist did not have this reflected in the long term care plan, (ii) There was no documented evidence of weekly or monthly weighs or observations in all six files. Weekly blood sugar level monitoring for a rest home resident with diabetes had not been completed since mid-November.</p>	<p>(i)Ensure that resident needs are reflected in the care plans, (ii) Ensure monitoring of blood sugar levels and weights are documented according to direction</p> <p>60 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>There is an activities section in the resident file that includes an activities assessment, life experiences' care and an activities care plan.</p>	<p>All six resident files had incomplete activity care plans in place.</p>	<p>Ensure that individual activity plans are documented fully and reflect the individual needs of each resident.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Low</p>	<p>Three long term care plans documented evaluation and review six monthly.</p>	<p>There was no review or evaluation completed six monthly of one long term care plan. [The other two care plans were not in place (link 1.3.3.3)].</p>	<p>Ensure that care plans are evaluated and updated six monthly and as needed.</p> <p>90 days</p>
<p>Criterion 1.4.6.3</p> <p>Service providers have access to designated areas for the safe and hygienic storage of cleaning/laundry equipment</p>	<p>PA Low</p>	<p>There is a designated safe locked chemical storage area.</p>	<p>Chemicals were observed not stored safely throughout the facility</p>	<p>Ensure that all chemicals are always safely stored.</p> <p>30 days</p>

and chemicals.				
<p>Criterion 3.5.7</p> <p>Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner.</p>	<p>PA Moderate</p>	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data collection, collation and analyses to identify areas for improvement or corrective action requirements have been the responsibility of the registered nurse since September 2013.</p>	<p>(i) There was no documented evidence that infection control data has been collected, collated, analysed and reported back to staff since July 2014. (ii) Not all residents have an individual infection form completed as per policy.</p>	<p>(i) Ensure that all infection control data is collected, collated, analysed and reported to staff monthly. (ii) Ensure that all residents have an individual infection form completed for identified infections or signs and symptoms of infection</p> <p>30 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p>	<p>PA Moderate</p>	<p>The service has an approval process (as part of the restraint minimisation and safe practice policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. The restraint assessment identifies specific interventions or strategies to try (as appropriate) before using restraint (link 1.3.3.3). Three resident files were reviewed, two with restraint and one with an enabler. The residents all have appropriate consent forms in place.</p>	<p>There was no documented evidence of monitoring for the three residents with restraint/enablers.</p>	<p>Ensure that monitoring of the resident with restraint and enablers occurs and is documented.</p> <p>60 days</p>

<p>(f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.</p>				
<p>Criterion 2.2.4.1 Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of</p>	<p>PA Low</p>	<p>There is a restraint evaluation form. Use of restraint is discussed at staff meetings (# link 1.2.3.6).</p>	<p>There was no documented evaluation of restraint/enabler use being completed.</p>	<p>Ensure that all episodes of restraint and enablers are evaluated according to policy and at least six monthly.</p> <p>90 days</p>

<p>the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers.</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.