Vinada Limited

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:	Vinada Limited
Premises audited:	Voguehaven Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 January 2015 End date: 7 January 2015

Proposed changes to current services (if any): Click here to enter text

Total beds occupied across all premises included in the audit on the first day of the audit: 22

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
	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

Voguehaven rest home provides rest home level care for up to 26 residents. On the day of audit, there were 22 residents. The resident care manager (owner/director) has 15 years' experience working in aged care. Management is supported by a part-time registered nurse (RN) who lives on site and available for residents and staff. Residents and families interviewed were complimentary about the care and service received.
Six of 12 shortfalls identified in the previous audit have been addressed. These are around collation of surveys, pain assessments, medication reconciliation, food safety, calibrating and servicing of equipment and the registered nurse job description. Improvements continue to be required around incident management, human resource and employment documentation, performance appraisals, resident and family involvement in care planning and activity plans and care interventions.

This audit has also identified improvements required around staff meetings/minutes, collation of incident data, corrective action planning, internal audits, complaint documentation, the hazard register, staff orientation records, first aid training, timeliness of assessments, care and activity plans, only the registered nurse (RN) completing care plans, aspects of medication management, dietitian review of the menu and electrical tagging.

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.

Open disclosure is practiced and management are at the facility daily and interact with residents and families. There is an improvement required around documenting when family are informed of incidents. The complaints system is well understood by residents and family. Complaints are investigated, discussed at staff meetings and changes to practice are made as a result of complaints.

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 organisation has a business plan in place with quality objectives that are linked to the quality improvement system. The service has implemented policies and procedures. There are improvements required around staff meetings, internal audits, collation of incident data and incident management and the hazard register.
Staff receive ongoing education. The staffing roster indicates there are adequate numbers of staff on duty to safely deliver care within a timely manner. The RN works part-time and available on call.

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.

The registered nurse is responsible for each stage of service provision. The GP completes three monthly reviews.
The residents' needs, objectives/goals have been identified in the long-term care plans and these are reviewed at least six monthly or earlier if there is a change to health status. The activity programme is resident focused and provides a variety of activities to meet the interests and abilities of the consumer group. Community links are maintained.
Education and medicines competencies are completed by all staff responsible for administration of medicines. The medicines records reviewed include photo identification. All meals and baking is prepared and cooked on site.

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 building is safe and well maintained with a current building warrant of fitness. There are suitable outside areas for residents. Scales have been calibrated and the hoist serviced.

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.

There are comprehensive policies and procedures that meet the restraint standards. There are no residents with restraints or enablers. Restraint and challenging behaviour training has been provided.

Infection prevention and control

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

The registered nurse is the infection control co-ordinator and has an appropriate job description. Infection data is collected, analysed and collated with opportunities for improvements identified.

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	8	0	5	5	0	0
Criteria	0	27	0	10	6	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	There have been seven complaints in 2014 and all are documented in a complaints register/book that documents the investigation and actions implemented as a result of the outcome. There is evidence of changes being made as a result of complaints including an increased in staffing. Staff interviewed are knowledgeable in the complaints and concerns process. Outcomes of the complaints are discussed at the staff meetings. D13.3h. A complaints procedure is provided to residents within the information pack at entry. Discussion with five residents and three relatives confirmed they were provided with information on complaints and complaints forms and are comfortable approaching management with any concerns/complaints. Improvement is required around documentation of communication with the complainant.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an	PA Low	The management promote an “open door” policy. Relatives and residents are aware of the open door policy and confirm on interview that the staff and management are approachable and available. The RN lives on site and is available to meet with residents and families after hours if required. Information is provided in formats suitable for the consumer and their family. There are residents meeting held regularly with opportunity for feedback on the services. Annual resident, relative and food surveys are completed that provide feedback on all areas of the service.

environment conducive to effective communication.		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 Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry. Three relatives and five residents interviewed stated they were given sufficient information prior to entry to the service and had the opportunity to discuss information and the admission agreement with management. 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. D16.4b Three relatives stated that they are always informed when their family member's health status changes however this is not documented for incidents. D11.3 The information pack is available in large print and advised that this can be read to residents. Interpreter services can be accessed if required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Voguehaven is a 26 bed home, which provides a homely environment. On the day of audit there were 22 residents including one resident on respite care. The owner/directors directly co-ordinate the operational management and service delivery. There are three directors with specific roles. One of the directors is the resident care manager. She attends two to three monthly DHB managers' meetings and is mentored by two more experienced aged care managers. Voguehaven is a member of the New Zealand Aged Care Association and attends training and updates as offered. The resident care manager is supported by a part-time RN (eight hours a week) who lives on site and is available 24 hours for clinical concerns. There is a governance quality plan for 2013 to 2014, which is currently being reviewed to develop the 2015 plan. Ten goals have been identified.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects	PA Moderate	Staff meeting minutes sighted evidence there discussion around concerns, compliments, health and safety, infection control, audit and survey results and corrective actions and improvements. Staff interviewed state they are well informed and receive quality and risk management information. However meeting minutes are not available for all meetings. Where meeting minutes have been completed, these did not all reflect discussion of accident/incidents or infection control surveillance data. The management committee meeting is held three monthly. Each area such as health and safety, infection control and clinical provide reports. Internal audit results are discussed. Implementation of corrective actions are the responsibility of the directors. The audit results analysis form is available for corrective actions from audits. Improvement is required around corrective action planning. There is an internal audit schedule. Internal audits are completed. Improvement is required around implementation of the internal audit schedule.

continuous quality improvement principles.		Surveys completed are; resident care (September 2014) and family survey (September 2014). The results have been collated to identify any areas for improvement. This is an improvement since the previous audit. D5.4: The service has the appropriate policies and procedures to support service delivery and all are current. D19.3: There is a quality and risk management programme in place that includes health and safety and hazard identification. Staff report any hazards identified on the daily maintenance request/hazard form. The hazard register is dated and includes recorded hazards (and controls) as per maintenance/hazard form. This has not been reviewed and updated since 2013. This is a previously identified shortfall that continues to require improvement. D19.2g: Falls prevention strategies are in place. Organisational risks are documented in the business continuity plan. There is evidence of monthly collation, analysis and monitoring of infection control, restraint use and audit outcomes. There is improvement required around collation of accident/incident data. Staff interviewed state they are kept informed, receive information and discuss risk management and hazard identification and management at the staff meetings.
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.	PA Moderate	Falls management and prevention includes analysis of time and location. Corrective actions and monitoring requirements are linked to the long term care plan such as the use of a sensor mat. When an incident occurs the staff member discovering the incident completes the accident/incident form. The incident/accident is documented in the progress notes. There is no evidence of RN involvement on accident/incident forms sampled. This is a previously identified shortfall that has not yet been addressed. There continues to be a shortfall around notifying families of incidents (link 1.1.9.1). Improvement is required around analysing incidents to minimise the risk of recurrence, The RN collects incident, investigates and reviews, and implements corrective actions as required. Monthly data is taken to the management committee meeting and staff meetings. However this has not occurred for 2014 (link 1.2.3.6). The caregivers interviewed could describe the process for reporting of incidents and accidents. D19.3b; There is an accident/incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action. D19.3c. Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications.
Standard 1.2.7: Human Resource Management Human resource management	PA Moderate	Five staff files were reviewed. There are improvements required around staff employment documentation and performance appraisals. The RN has a current practicing certificate. Five of five staff files sampled did not evidence reference checks. However the two staff files reviewed for new staff members did not require reference checks as they were known to the directors. There are no signed job descriptions in five of five staff files sampled. This is a previously identified shortfall that continues to require improvement.

processes are conducted in accordance with good employment practice and meet the requirements of legislation.		There is a comprehensive orientation programme. Staff are orientated to their area of work and complete competencies relevant to their role. There is a documented in-service programme for education that covers compulsory requirements. At least eight hours of staff development or in-service education has been provided annually. Not all staff have a current first aid certificate. Competencies are identified and completed. Staff responsible for medication administration complete annual competencies. Caregivers are encouraged and supported to undertake external education.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Staffing rosters were sighted and there are an adequate number of staff on duty to meet the resident's needs on different shifts. The (owner/director) is a qualified caregiver and provides cover as the second caregiver as required between shifts from 1pm to 3pm. The registered nurse (RN) lives on site and is available on call for clinical concerns. A casual RN provides covers for the RN on leave. The directors are available on call for facility or staffing matters. Five residents interviewed confirm that there are sufficient staff on site at all 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.	PA Moderate	The blister pack medication administration system is being implemented. There is an improvement required around the management of eye drops and having 'stock medication. Medications are checked against the prescription by the registered nurse when they are delivered. This is an improvement since the previous audit. There were no residents prescribed controlled medications. Medication requiring refrigeration is stored in a sealed container in the kitchen fridge. The fridge temperature has been recorded daily (sighted). There were no residents self-administering medication. However there are processes in place should this occur and the registered nurse was able to describe these. The pharmacy is available for advice and support, as and when required. Ten medication charts sampled had medications correctly prescribed. The charts were clear and easy to read. Ten of ten medication records sighted include a photograph of the resident for identification purposes and eight of ten have allergies/adverse reactions noted. All staff responsible for medication management have completed annual medication competencies. Medication administration training was completed in March 2014. D16.5.e.i.2; Ten out of ten resident files viewed identified that the GP had seen and reviewed the resident three

		monthly and noted in the file that medications had been reviewed. All medications prescribed are dated and signed by the GP. Improvement is required around the administration of eye drops.
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.	PA Low	The service employs a Monday to Friday cook and a weekend cook. There are two kitchen hands who work the tea shifts. The week day cook has completed the national certificate level three in hospitality. The director/manager is a chef (City Guilds) and monitors the food services. There is a summer and winter menu which requires review by a dietitian. Food safety and hygiene training was completed in June 2014. This is an improvement since the previous audit. The meals are served at times that reflect community norms. Any dietary requirements are identified in the dietary profile, which is undertaken on admission and updated as required. Residents for food likes, dislikes and allergies is recorded in care plans and communicated to the cook and these are accommodated. There are weekly cleaning schedules that are implemented. This is an improvement since the previous audit. There are daily temperature recordings of the freezers and chiller and three monthly random checks on hot food temperatures. This is an improvement since the previous audit. Residents and family members interviewed report very positively about the food provided.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The previous audit identified that pain assessments were not completed and the effect of pain relief was not documented for residents with pain. One resident file is for a resident who takes regular analgesia and this person has a pain assessment and when PRN pain relief is given the effect is documented. The previous shortfall has been addressed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	PA Low	Residents and family member interviews confirm care delivery and support by staff is consistent with their expectations and their needs are being met. . Caregivers inform the RN promptly if there are any changes to resident's health status. The RN initiates a GP review. The previous audit identified that care plans did not include interventions for all identified needs (including short term needs and enabler risks). The five files sampled in this audit have all relevant issues addressed in the care plan. There are no residents using restraint or enablers. The previous shortfall has been addressed. Improvement is required around completing neurological observations after a knock to the head. D 1.3and 4 Dressing supplies are available and there is a well-stocked cupboard. There are wound assessments

desired outcomes.		and wound care plans in place for all wounds. Continence products are available and resident files identify the type of product required for day use, night use and other management. Specialist continence advice is available as needed by GP referral.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	There is one activity coordinator employed for six hours, one day per week. Outside of this time activities are provided by other staff and management. There is a varied activity programme documented each month with includes activities over seven days and includes at least three outings per week. Activities provided reflect residents' strengths, skills and interests, which are identified by the resident and/or family/whanau on admission. Residents interviewed confirm activities are provided to meet their interests and skills over seven days. Residents are able attend church services outside of the facility with family and friends. Residents are involved in local community activities. Residents' activities profiles are completed and activities are individualised according to residents' preferences and interests. Discussions occur between the activities co-ordinator and residents to plan the day's activities as witnessed on the day of the audit. Activity plans are individualised and all are current. However they were not completed soon after admission (link 1.3.3.3) and there continues to be a lack of evidence that residents and families are involved in the development of activity plans (link 1.3.3.4).
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Evaluations are conducted by the registered nurse six monthly or when a resident's condition alters. Three of five care plans sighted on the day of the audit were evaluated according to policy timeframes. One resident is on respite care and another has not yet been at the service for six months. Care staff monitor resident's progress on a shift-by-shift basis and report any concerns to the resident care manager or the RN. Staff document concerns in resident's progress notes, as sighted. There is a general practitioner review every three months and on an as required basis.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	PA Low	A current Building Warrant of fitness is displayed at the entrance to the facility and expires 1 April 2015. The building is well maintained. Water temperatures are maintained at 45 degrees. Interviews with three caregivers confirm there is adequate equipment. Electrical tags are expired. This is a previously identified shortfall. Scales calibration and annual functional test of the hoist occurred last in August 2014. This is an improvement since the previous audit. There are safe outside areas that are easy to access for residents and family/whanau members. D15.3d The lounge areas is designed so that space and seating arrangements provide for individual and group activities with the activity programme offered in the lounge on the day of the audit.

for their purpose.		ARC D15.3; The following equipment is available: pressure relieving mattresses, wheel chairs, shower chairs, hoist, scales and mobility aids.
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	The RN job description defines responsibilities for infection control. This is an improvement since the previous audit.
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	Infection surveillance is an integral part of the infection control programme. Monthly infection data is collected for all infections. This data is monitored, graphed and evaluated monthly and annually. Outcomes and actions are not discussed at the staff meetings (link 1.2.3.6). If there is an emergent issue, it is acted upon in a timely manner. No outbreaks were noted in the past 18 months.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. The service currently has no residents on restraint or using enablers.

minimised.		

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	All complaints are documented in a complaint register that includes investigation and actions taken. There is evidence of changes being mad as a result of complaints including an increase in staffing.	Seven of seven complaints for 2014 do not have evidence of acknowledgement letters or letters of outcomes being sent to complainants.	Ensure that all complaints are acknowledged and the complainant informed of the outcome and informed of the right to advocacy and the right to complain to the Health and Disability Commission if unhappy with the outcome. 90 days

Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	The caregivers and residential house manager report that they often inform families of incidents when they next visit but this is not documented. Three of three families interviewed report they feel well informed. One of eight incident forms for December 2014 indicates that family were informed. A brief extension of the sample for four other incidents in August 2014 and November 2014 show family were informed,	Seven of eight incidents for December 2014 did not have documented evidence that family were contacted.	Ensure that families are contacted when there is a change in residents care or condition or an incident. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	There is an internal audit schedule and audits are completed each month. Caregivers and the residential home manager report staff meetings occur four to five times per year. There is a standing agenda for staff meetings that includes incidents, complaints, internal audits and infections. Minutes for staff meetings sighted for February 2014 and July 2014 show discussion around complaints and issues identified in audits. There is also discussion about the completion of incident forms.	(i) Staff meeting minutes were not available for the staff meetings in May and September 2014. (ii) The staff meeting minutes for February and July 2014 did not contain evidence of discussion around infection trend analysis or incidents. (iii) Incident data has not been collated or graphed for 2014. (iv) The internal audit schedule has not been fully implemented as not all scheduled audits have been completed each month.	(i) Ensure that staff meeting minutes are available for reference. (ii) Ensure that infection and incident data analysis results are discussed in staff meetings. (iii) Ensure incident data is collated and analysed for trends. (iv) Ensure the internal audit schedule is fully implemented. 90 days
Criterion 1.2.3.8	PA	When a shortfall is identified in an audit	(i) Corrective action plans	(i) Ensure

A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	Moderate	there is an audit report form that documents required corrective actions. These have been completed for some of the internal audits sampled. There is evidence in staff meeting minutes and interview with two caregivers that internal audit results result in improvement. An audit report form has been completed for each of the monthly medication administration reports. The monthly medication administration audit identified issues every month for which a corrective action plan was developed,	have not been completed for every audit where shortfalls have been identified. (ii) The corrective action plan for the medication administration audit has not been reviewed for effectiveness. (iii) Where corrective action plans have been developed there is no documented evidence to demonstrate these have been implemented and signed off as completed.	corrective action plans are developed for all identified service shortfalls. (ii) Ensure corrective action plans are effective to address the shortfall. (iii) Ensure corrective action plans are signed off when they have been implemented. 90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Moderate	There is a hazard plan that documents relevant hazards and has been updated in 2012 and 2013. The two directors (the residential home manager and the maintenance manager) interviewed are able to describe how business risks are minimised.	(i) The hazard management plan has not been reviewed or updated since 2013. This is a previously identified shortfall that has not yet been addressed.	(i) Ensure the hazard plan is updated and reviewed regularly. 90 days
Criterion 1.2.4.3 The service provider documents adverse,	PA Moderate	When an incident occurs the caregiver on duty completes a form. These are	(i) Eight of eight incidents for December 2014 did not have	(i) Ensure all residents are

unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		given to the residential care manager who ensures no urgent follow up enquiry is needed. The registered nurse (interviewed) and caregivers (two interviewed) report the registered nurse attends every incident where there is an injury.	documented follow up by the registered nurse. (ii) Seven of eight incidents did not document an analysis of the incident or opportunities to prevent recurrence.	followed up by the registered nurse following an incident. (ii) Ensure all incidents are reviewed and opportunities to reduce the likelihood of recurrence are identified. 60 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	The manager reports all new staff complete an application form and are interviewed.	(i) Two of the five staff files reviewed for staff who have been at the service for two months and more than one year respectively did not have staff files or any documentation relating to their employment. (ii) The remaining three staff files did not have a signed job description or performance appraisals. These are shortfalls that were identified in the previous audit and have not yet been addressed.	(i) Ensure all staff have an employment record/file with a contract, job description, application form, reference check and current performance appraisal. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	There is a comprehensive orientation workbook that covers all areas of responsibility. The workbook has been completed for three of five staff files sampled. Caregivers interviewed report they are buddied for one week	Two of five staff whose records were sampled did not have a documented orientation.	Ensure all staff complete a documented orientation.

		as part of the orientation and longer if required.		90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	All except two staff have a current first aid certificate and staff with expired or expiring first aid certificates are booked to attend a first aid course in February 2015.	There is not always a staff member on duty with a current first aid certificate	Ensure there is a staff member on duty at all times with a current first aid certificate. 90 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	The registered nurse reports that medications are administered according to GP instruction. Prompt sheets and insulin regimes are written out to prompt staff to give medications that are at out of ordinary times. Eight of ten medication charts have allergies documented and these are highlighted with a highlighter pen.	(i) Two of ten medication files have eye drops prescribed that are not being administered. (ii) There is evidence of transcribing on staff prompt sheets and insulin regime sheets. (iii) There are stock medications which are not prescribed to a specific resident. (iv) Two of ten medication charts do not have allergies documented.	(i) Ensure medications are administered as prescribed. (ii) Cease the practice of transcribing. (iii) Ensure all medications are dispensed for a specific resident. (iv) Ensure allergies are documented for every resident. 90 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	There is a four weekly rotating menu for summer and winter that was reviewed by a dietitian in 2010. One of the directors is a City and Guild of London qualified chef who has input into the menu.	The menu has not been reviewed by a dietitian since 2010.	Ensure that the menu is reviewed regularly by a dietitian.

				180 days
Criterion 1.3.3.1 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.	PA Moderate	The registered nurse works eight hours per week and completes initial and ongoing assessments and long term care plans and care plan evaluations. If an admission occurs on a day that she works she completed the initial care plan.	Three of five files sampled have the initial (short term) care plan completed by the residential care manager who is not a registered nurse. There is no evidence of input by the registered nurse.	Ensure the registered nurse completes all care plans. 60 days
Criterion 1.3.3.3 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.	PA Low	Four of five resident files sampled have an initial assessment completed at admission and three of five have a long term care plan completed within 21 days of admission (one resident is on respite care. All residents are seen by the GP within 48 hours of admission unless they are admitted directly from hospital.	The respite resident has had two admissions and has not had any assessment completed. One other resident did not have a long term care plan completed within three weeks of admission. Four residents with activity assessments and plans (the respite resident does not require these) did not have them completed until between three and 15 months after admission.	Ensure all residents have an assessment completed within 24 hours of admission and a long term care plan within three weeks of admission and an activity plan completed in a timely manner. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	Caregiver's document progress notes for every resident every shift. In one file sampled the registered nurse had documented an intervention in the progress noted sampled. Progress notes were sampled from 30 November 2014 to the day of the audit.	(i) In four of five files sampled the registered nurse has not had input into progress notes for notes reviewed back to 20 November 2014. (ii) Four of four long term care plans and activity plans did not document family or resident involvement	(i) Ensure the registered nurse documents on-going input into resident care. (ii) Ensure family and residents (where able) are included in the development

			in the development of the plan.	of care and activity plans and that this is documented. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	The registered nurse is available on call 24 hours per day and lives on site. A review of eight incident forms show that for six no treatment was required and for one a wound plan was developed.	One incident form for a resident who had a fall and hit their head did not have follow up assessment such as neuro obs completed.	Ensure an appropriate follow up assessment is completed when a resident hits their head. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	One of the directors attends to maintenance issues. Maintenance requests are recorded on a form and signed off as complete.	Equipment electrical warrant of fitness tags expired in February 2014. This issue was identified in the previous audit and continues to require attention.	Ensure all equipment is checked for safety, calibrated and maintained to manufacturer's recommendations. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.