

Marton Edale Home Trust Board

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: Marton Edale Home Trust Board

Premises audited: Marton Edale Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 23 January 2015 End date: 23 January 2015

Proposed changes to current services (if any): Increased dementia level beds by two and decrease rest home beds by two.

Total beds occupied across all premises included in the audit on the first day of the audit: 27

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

Marton Edale Home is a non-profit organisation and governed by community trust board of combined local organisations and the churches. The home provides care for up to 30 rest home and dementia residents. On the day of the audit, there were 27 residents. The home has increased dementia level care beds from 9 to 11 by adding two rest home beds into the dementia unit. As part of the surveillance audit these two rooms were reviewed and were identified as suitable to provide dementia level care. Secure doors have been removed to accommodate these two rooms and also a second lounge added to the unit. The residents and families interviewed all spoke positively about the care and support provided.

The service has addressed five of six previous audit shortfalls around the quality and risk management system, emergency water supply, medication signing gaps, recommendation of specialists and signed job descriptions. There continues to be an improvement required around care plan evaluations. This audit also identified further improvement required around staff training, documentation of medication reviews and medicine prescription by the GPs.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

Standards applicable to this service fully attained.

There is a policy to guide staff on the process to ensure full and frank open disclosure. Document review evidenced communication to the residents' family or person with enduring power of attorney about any significant changes to the resident. There is a complaints register that is up to date.

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 quality and risk management system is implemented. Complaints, incidents, accidents and infections are collated and reported. Quality data and corrective actions are reported through the quality system. Staff are involved in quality and risk activities through involvement in completing audits / surveys, incident / accident reporting and attending staff education. Staff can access quality data and feedback also occurs through the staff and quality meetings. Audits, hazards, health and safety and infection control results were discussed. Quality and risk information is also discussed at the Board meetings. Human resource policies are implemented for recruitment, selection and appointment of staff. All staff signs job descriptions this in an improvement

since the previous audit. Annual training plan is implemented. Rosters show all shifts are adequately covered. The Clinical Nurse Leader works full time and there is also an additional registered nurse cover over four days a week which includes weekend cover.

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.
--	--	--

Nursing assessments and care plans are completed by the Clinical Nurse Leader and the registered nurse. Care plans are evaluated six monthly or when there is a change in residents' health status. Short term care plans are utilised for infections, wounds and any change in residents' condition. Residents and families are involved in the care planning process and they were informed of any changes in health care status. There is a planned activities programme that involves the wider community. The residents have a nutritional assessment completed on admission and dietary requirements, likes and dislikes are recorded. Nutritional assessments are evaluated six monthly as part of the care plan review. Changes to residents' dietary needs are communicated to the kitchen. Special diets are catered for to meet residents' needs. There is a medication management policy that clearly documents the responsibilities of staff for each stage of medication management.

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 has a current Warrant of Fitness. The service has addressed the previous finding around emergency water supply. However this audit identified an improvement required around on-going maintenance.

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.

Staff received training around restraint minimization and the management in challenging behavior. On the day of audit, there were no enablers or restraint use in Marton Edale. The home has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint or enabler use should these be required.

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 Clinical Nurse Leader uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Surveillance data is collected monthly and analyzed for trends and reported back to staff. Surveillance is a standard agenda item at staff /quality meetings.

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	13	0	2	2	0	0
Criteria	0	37	0	2	3	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.	FA	<p>There are policies and procedures setting out the resident's right to complain about the service. Staff receive training about the right to complain and are aware they have a responsibility to record any issues that arise.</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. The register includes six complaints for 2014 and one of these complaints is open and under investigation by the Business Manager. Residents / families interviewed confirmed that they are aware of who to make a complaint to if required.</p> <p>Complaint register includes complaints that escalated to the Health and Disability Advocacy services, the local DHB and the MOH. All communications related to these complaints were kept in the complaint register.</p> <p>D13.3h: A complaints procedure is provided to residents within the information pack at entry.</p> <p>E4.1biii. There is written information on the service philosophy and practices particular to the unit included in the information pack.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Verbal and written communication was noted. On the day of audit, staff were observed communicating in an individualised and appropriate manner to residents and their families. Open disclosure procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Seven resident files sampled evidenced communication to the residents' family or person with enduring power of attorney about any significant changes to residents. Two family members (one from each area) interviewed confirmed this.</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>	FA	<p>Marton Edale Home is a non-profit organisation and governed by a community trust board of combined local organisations and the churches.</p> <p>The home provides care for up to 30 rest home and dementia residents (19 rest home and 11 dementia level care). The current occupancy is 27 residents (19 rest home residents and eight dementia level care). The home has increased dementia level care beds from 9 to 11 by moving a door and now including two rest home beds as part of the secure dementia unit. As part of this surveillance audit, these two rooms were verified as suitable to provide dementia level care. Secure doors had been removed and re-located to accommodate these two rooms and also the second lounge was added to the unit.</p> <p>The Business Manager reports directly to the board and meets two monthly (six to eight weekly). This is confirmed by the Clinical Nurse Leader and the Finance Manager. On the day of audit, the Business Manager was on leave.</p> <p>Marton Edale has a 2013-2015 Business Plan. There is also 2015-2020 Strategic Plan which is in a draft format.</p> <p>The Business Manager and the Clinical Nurse Leader have maintained their positions since the previous audit.</p> <p>E2.1: The philosophy of the service also includes providing safe and therapeutic care for residents with dementia that enhances their quality of life and minimizes risks associated with their confused states.</p> <p>D17.3di (rest home) The Business Manager and Clinical Nurse Leader have maintained at least eight hours professional development activities related to managing a rest home and dementia unit, annually.</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>FA</p>	<p>The quality and risk management system is implemented. The Clinical Nurse Leader and the Business Manager are both responsible for coordinating the quality management system. There is collection of data from a wide range of sources within the service. Consumer satisfaction survey 2014 was completed and shows 97.5 % satisfaction. Complaints, incidents, accidents and infections are collated and reported. Information and corrective actions are reported through the quality system. Staff are involved in quality and risk activities through involvement in completing audits / surveys, incident / accident reporting and attending staff education. Staff can access quality information, and feedback also occurs through the staff and quality meetings. Audits, hazards, health and safety and infection control (IC) results are discussed in these meetings. Quality and risk management information was also discussed at the Board meetings.</p> <p>Staff interviewed (one cleaner, one cook, three caregivers and the Clinical Nurse Leader) confirmed that they understand and are involved in the quality programme. Examples given were completing an incident form, dealing with complaints or reporting complaints and attending staff meetings.</p> <p>Marton Edale has policies and procedures that describe the management of risks. There is a hazard register. Hazard forms are available for use and are seen to be utilised. The service collects information on resident incidents and accidents as well as staff incidents/accidents.</p> <p>Pervious audit identified issues around discussion of the quality data in the meeting minutes and closure of issues from the previous meetings. Review of the meeting minutes showed that quality data has been discussed in the staff /quality meetings. Meeting minutes reflect feedback and discussion on quality data, and opportunities for improvement where appropriate. Meeting minutes included closure of issues from previous meetings. Five issues were selected in the meeting minutes, and closure of these issues was checked. Three of these issues were noted as completed and this was confirmed by the Clinical Nurse Leader, the Finance Manager and the three caregivers. In two occasions same issues were also discussed in the health and safety meetings where closure of issues was noted, and these issues were confirmed by the staff as closed off. The required previous corrective actions around implementation of the quality system have been addressed.</p> <p>The annual staff training programme is implemented that is based around policies and procedures.</p> <p>D10.1 Death/Tangihanga policy and procedure that outlines immediate action to</p>
---	-----------	--

		<p>be taken upon a consumer's death and that all necessary certifications and documentation is completed in a timely manner.</p> <p>D17.10e: There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>D19.3 There is implemented risk management, and health and safety policies and procedures in place including accident and hazard management</p> <p>D19.2g Falls prevention strategies such as falls risk assessment, walking aids, use of appropriate footwear, correct seating, increased supervision and monitoring and sensor mats if required.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Policies and procedures are set out and implemented for the collection and management of adverse events. Such events include complaints, infections, agitation and medication errors, falls, bruises, hazards, staff injuries, wandering and other incidences. These are recorded and investigated. Staff and management are involved in the collection of adverse events. The incidents forms are reviewed and investigated by the Business Managers or Clinical Nurse Leader. Incidents are trended monthly and reported to three monthly staff /quality meetings.</p> <p>Discussion with the Clinical Nurse Leader indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. Ten Incidents/accidents for November 2014 reviewed showed that issues and trends are monitored. Preventative and corrective actions were documented as required. Actions were reflected in resident's long term care plans where appropriate.</p> <p>D19.3b: There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>Human resource policies are implemented for recruitment, selection and appointment of staff. There is an orientation/induction programme. Annual performance appraisals are completed. There is an annual education/training plan in place that has been implemented and training is recorded for individual staff however not all staff have completed minimum eight hours training per annum. Two caregivers working in the dementia unit have not completed required dementia</p>

		<p>standards.</p> <p>There is a record of staff qualifications and copies are on staff files. Copies of the RN's practicing certificates are maintained. Interview with three caregivers (one rest home and two dementia) informed there is access to sufficient training. Medication competencies are completed by the RNs and caregivers who administer medication. These are checked by the Clinical Nurse Leader.</p> <p>Seven staff files are reviewed and all had signed job descriptions. This is an improvement since the previous audit.</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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Staff reported that staffing levels were adequate and they were well supported by the management. There are a total of 40 staff members.</p> <p>The Business Manager works 30 hours a week. The Clinical Nurse Leader works full time and there is also an additional RN over four days a week which includes weekend cover. Rosters are in place for allocation of caregiving staffing levels across shifts.</p> <p>Resident and family interview confirmed that there is sufficient and appropriate coverage for the effective delivery of care.</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>	PA Moderate	<p>There are comprehensive medication policies in place. Medication fridges are monitored and recorded weekly. Medication reconciliation is completed on admission and the policy includes guidelines on checking on arrival. All medication is stored in a locked medication room.</p> <p>All staff administering medications have completed an annual medication competency. Staff maintained contact with the medication trolley when administering medications. There are no residents who self-administer medicines. This audit identified improvements required around medication prescribing and documentation of medication reviews.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid	FA	There are food policies/procedures for food services and menu planning appropriate

<p>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>for this type of service. Dietitian input was obtained in 2013. Residents needing specific dietitian support are identified, and referrals are made appropriately and recorded in the file. Interview with the cook confirms that resident dietary needs are catered for. The kitchen produces normal diet, soft diet, pureed diet, gluten free diet and diabetic diet. Nutritional supplements are provided, and a stock is sighted in the kitchen.</p> <p>All residents have a nutritional profile developed on admission which identifies dietary requirements; assistance needed; special equipment; likes and dislikes. Any changes to residents' dietary needs are communicated to the kitchen. Dietary requirement are reviewed as part of the care plan review at least six monthly and on an as needed basis. Residents weights are regularly monitored and sample files did not include any unexpected weight lost.</p> <p>Daily temperature checks of chiller, freezers, and the food temperatures are maintained.</p> <p>E3.3f, There is additional nutritious snacks available over 24 hours.</p> <p>D19.2 staff have been trained in safe food handling.</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>FA</p>	<p>Seven resident files were reviewed. Care plans were well documented with the exception of one dementia level care file. See CAR 1.3.8.2. All five residents interviewed reported their needs were being appropriately met. The assessments were reflected in the long term care plans and identify the level of assistance each resident requires, as well as goals and objectives.</p> <p>Dressing supplies are available and a treatment room is appropriately stocked. Continence products are available and the resident files include documented continence assessments and bowel management. Continence products were identified for a day use and night use as well as other management.</p> <p>Wound assessment and wound management plans are in place for four wounds, including one surgical lesion and three skin tears. The wound intervention documentation is comprehensive and includes on-going evaluations.</p> <p>An interview with one of the visiting GP evidences that he is happy with the service and care provided.</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>FA</p>	<p>An assessment of residents likes and dislikes, social history, routines and interests are recorded for all residents in both the rest home and dementia unit and activities offered are appropriate for the residents.</p> <p>Resident interviews (five rest home residents) and family interviews (one from each area) confirmed that activities are enjoyable and community involvement is provided. Outings were scheduled fortnightly with community health shuttle which provides services for the community with donations only.</p> <p>D16.5d: Seven resident files reviewed identified that the individual activity plan is reviewed when at care plan review.</p> <p>Rest home activities are provided by an activities officer who has been in this role for five years. Activities programme in the dementia unit is directed by the caregivers and they were observed various times through the day diverting residents from behaviours. Recently, the second activities officer had resigned from her role. The Clinical Nurse Leader advised that this position has been filled and new activities officer will start in early February 2015.</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>The evaluation and care plan review policy require care plans are reviewed six monthly, or as their condition changes. Short term care plans were well utilised. Short term care plans were cited for wounds, antibiotic use, urinary tract infections and poor appetite. All initial care plans were evaluated by a RN within three weeks of admission. Changes to the long term care plans, including six monthly reviews were signed and dated by the RN; however one long term care plan evaluation in the dementia care did not reflect residents' current status. This was also a partial attainment from the previous audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The home has increased dementia level care beds from 9 to 11 by adding two rest home beds in to the dementia unit. As part of the surveillance audit these two rooms were checked and were identified as suitable to provide dementia level care. These two rooms have sufficient space for the safe manoeuvring of mobility aids. Internal and external areas are adequate to accommodate these two additional rooms. By adding these two rooms, dementia unit also had another lounge area within the unit.</p> <p>The building has a current Warrant of Fitness. The audit identified an improvement</p>

		required around on-going maintenance and hot water.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Kitchen maintains emergency food supplies, which are sufficient for three days. Extra blankets and alternative cooking facilities are available. The facility has civil defence kits and emergency equipment. Health and safety officer stated that the home maintains current stock levels, and regular checks are in place. Since the previous audit emergency water supply has been increased to 400 litres therefore required corrective action from the previous audit has been completed.
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	The infection surveillance policy describes, and outlines the purpose and methodology for the surveillance of infections. The Clinical Nurse Leader uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. IC programme is appropriate for the size and complexity of the service. The IC programme is linked with the quality plan. Internal IC audits assist the service in evaluating infection control needs. Surveillance data is collected monthly and analysed for trends and reported back to staff. Surveillance is a standard agenda item at staff /quality improvement meetings. Review of medical notes shows that GP's are notified if any sign of infections, laboratory reporting and if there is any resistance to antimicrobial agents.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint manual determines that enablers are voluntary and the least restrictive option. On the day of audit, there were no enablers or restraint use in Marton Edale. Staff received training around restraint minimization and the management in challenging behaviour. Three caregivers and the Clinical Nurse Leader interviewed were knowledgeable around restraint minimization and enablers. Marton Edale Home has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint or enabler use should these be required.

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 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Human resource policies are implemented for recruitment, selection and appointment of staff. All staff files reviewed including five caregiver files, an RN and the Clinical Nurse Leader had completed orientation documents.	E4.5f. There is nine staff members who work in the dementia unit. Two staff members who work in the dementia unit have not completed required dementia specific training. Staff members were employed in 2013 and 2012 and one has recently enrolled to undertake the study.	Ensure that staff who works in the dementia unit have undertaken required dementia level qualification within six months of employment and obtained the qualification within one year of employment. 180 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 Moderate	Annual training plan is implemented. Discussion with staff and the Clinical Nurse Leader confirmed that training programme includes relevant aspects of care and support and in relation to the requirements. The Clinical Nurse Leader maintains proficient level professional development and	Staff training records documented on the spread sheet and staff are encouraged to complete further training to achieve minimum eight hours training a year, however this schedule does not include external training. Therefore, it does not provide full picture to identify training needs of staff. Review of	Ensure that staff complete at least eight hours training annually and training records show all training completed. 90 days

		<p>recognition portfolio. He has attended several external training provided from professional agencies and the local DHB. The Clinical Nurse Leader has attended clinical manager's workshop in 2014. The RN has completed several training programs including online training related to the Dementia Care. Staff also attended palliative care link nurse meetings. Staff can access to a national training in care of elderly and the Clinical Nurse Leader is the training assessor.</p>	<p>staff training hours also showed that some staff members have completed less than eight hours training a year.</p>	
<p>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.</p>	<p>PA Moderate</p>	<p>Seventeen medication charts were reviewed (seven in dementia care and 10 rest home). Signing on administration was up to date and included times of administering for as required medications (PRN). All medication charts were signed and dated by the GP, including all stopped medications therefore required corrective action from the previous audit have been addressed. Resident photographs and allergies are on all medication charts. There are currently, three GP's who visit Marton Edale Home. The service is intending to introduce medimap.</p>	<p>Six medication charts (three from each area) were not written clearly by the prescribing GP and were not easy to understand. Ten medication charts (four dementia care and six rest home), PRN medications did not have indication for use included. Three medication charts (one dementia care and two rest home) did not have documented evidence of three monthly reviews by the GP.</p>	<p>(i)Review of all medication charts is required to ensure that all prescribed medications are clearly written by the GP or the prescriber. (ii) Review all PRN medications included on the medication charts and ensure that the indication for use is clearly identified. (iii) The GP clearly documents the medication reviews completed three monthly. 90 days</p>
<p>Criterion 1.3.8.2</p>	<p>PA</p>	<p>Care plan evaluation are completed</p>	<p>(i)One resident file reviewed in the</p>	<p>(i)Ensure that care plan</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.	Moderate	at least six monthly. Five out of six care plans evaluations reviewed (three rest home and two in the dementia care) identified a link between assessments and resident's needs.	dementia care did not have up to date evaluations of care plans completed. The care plan did not include triggers in management of behaviours that challenge as identified through the evaluation	interventions include identification of triggers in management of challenging behaviour. (ii) Ensure that review of the behaviour monitoring forms occur and care plan evaluation include outcome of current interventions. 60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	The building has a current Warrant of Fitness	(i) During the tour of the facility it was observed that three toilets in the dementia unit had broken vinyl flooring, (ii) Sluice room in the dementia unit does not have hot water available.	(i) Ensure that floorings in the toilets are being fixed. (ii) Ensure that hot water is available in the sluice room 180 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, 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.