# CHT Healthcare Trust - Amberlea Hospital and Rest Home

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** Amberlea Hospital and 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: 11 February 2015 End date: 11 February 2015

**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:** 64

# 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** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

CHT Amberlea provides care for up to 72 rest home and hospital residents. The occupancy was 64 residents on the day of the audit. Amberlea is part of the CHT organisation. The CHT group has strong board and effective governance practices. The manager is a registered nurse who has been in the role since September 2014. Resident and family feedback during the audit was very positive.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with residents, relatives, staff and management.

One of the four shortfalls identified at the previous certification audit and two of two shortfalls from the previous verification audit have been addressed. These were around consents, a certificate for public use and an approved evacuation scheme. Documented reviews by a registered nurse when health changes and appropriate provision of fluids have also been addressed. Improvement continues to be required around wound management, aspects of medication management and competency assessments for residents who self-administer medications.

This audit also identified improvement required around registered nurse review after incidents, staff training, informing relatives about incidents and care plan interventions.

## Consumer rights

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| 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. |

Amberlea practices open disclosure with residents and family reporting they are well informed. Complaints processes are implemented and there is a complaints register.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Amberlea has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Facility staff meetings indicate that the quality system is implemented. Residents are provided the opportunity to feedback on service delivery issues at monthly resident meetings, and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly. Amberlea has job descriptions positions that include the role and responsibilities of the position. There is an annual in-service training programme that has been implemented for the year and staff are supported to undertake external training. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing and healthcare assistants, residents and family members reported staffing levels are sufficient to meet resident needs.

## Continuum of service delivery

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| 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. |

Care plans are individualised and risk assessment tools and monitoring forms are available. Care plans are evaluated six monthly. The resident and family/whanau interviewed were complimentary about the staff and standard of care provided.

The team of two activity co-ordinators and two healthcare assistants provide a seven day activities programme for the residents that is varied, interesting and involves community visitors and outings.

Staff responsible for medication administration complete annual competencies and education. The general practitioner (GP) reviews the medication chart three monthly.

An external contractor prepares meals on site and the menu has been approved by a dietitian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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| 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. |  | Standards applicable to this service fully attained. |

Amberlea Hospital and Rest Home holds a building warrant of fitness and a certificate of public use. The service has a New Zealand Fire Service approved evacuation scheme.

## Restraint minimisation and safe practice

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| 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 is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There were no residents requiring restraints and no residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

## Infection prevention and control

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

The infection control coordinator is a registered nurse. Infection information is collated monthly. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **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 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 35 | 0 | 4 | 2 | 0 | 0 |

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| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The previous audit identified that not all files had completed consent forms. A review of five resident files (two rest home and three hospital) for this audits demonstrated that all sampled files now have consent forms signed by either the resident or their EPOA. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Information about complaints is provided on admission. Residents interviewed understood the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaints register. Complaints for 2014 and January 2015 were reviewed. All complaints have noted investigation, time lines, corrective actions when required and resolutions. Results are feedback to complainants.  Discussions with residents and family members confirmed that any issues are addressed and they feel comfortable to bring up any concerns. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | On interview five of five residents (two rest home and three hospital), four family members (two rest home and two hospital) and seven health care assistants, one registered nurse, one activities coordinator and the clinical coordinator all stated that residents and family are informed following changes in the residents’ health status. Contact records were documented in all files reviewed. However, not all incident forms sampled indicated family were informed or if family did not wish to be informed.  Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur.  Resident meetings occur monthly and issues arising from the meeting are fed back to staff meetings. Issues raised generate an investigation and corrective action plan. There is a policy that describes the availability of interpreter services when required.  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 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: Family members stated that they are always informed when their family members health status changes. D11.3: The information pack is available in large print and advised that this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Amberlea is a purpose built rest home and hospital facility. The service provides care for up to 72 rest home and hospital residents. The current occupancy is 32 rest home residents and 32 hospital residents including one respite resident. Amberlea Hospital and Rest Home is certified to provide medical services under the hospital component of its certificate. At the time of the audit, there were no residents under this category of care. Amberlea Hospital and Rest Home is part of the CHT organisation.  Amberlea has a current business plan and a quality assurance and risk management programme that outlines objectives for the next year and aligns with the CHT operational strategic goals and business plan.  The manager is a registered nurse who has been in the role for five months and was briefly clinical co-ordinator prior to this role. She had been working for the service casually since September 2014. She has a background in palliative care. The clinical coordinator has been in her position since November 2014 and has previous aged care experience. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Amberlea has a quality framework that is being implemented. There is a quality assurance plan which includes internal audit, incident collation, infection surveillance and hazard management. Interview with staff inform an understanding of the quality activities undertaken at Amberlea.  Resident meetings occur monthly. Annual surveys are conducted of residents and relatives.  Minutes include timelines, responsibilities and the completion of actions. The area manager completes a six monthly internal spot audit covering all areas of the service. All issues found in the 2014 audits have identified corrective action plans and resolutions. Results of audits are discussed in staff meetings.   There is a hazard register that is reviewed annually. All hazards are reported on a hazard form and documented as closed when corrective and preventative actions are complete.  D5.4 The service has appropriate policies/ procedures to support service delivery; Policies and procedures align with the client care plans and have been reviewed. D10.1: Care of the deceased resident procedure that outlines immediate action to be taken upon a consumer’s death and that all necessary  certifications and documentation is completed in a timely manner. D19.3: There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. D19.2g: Falls prevention strategies such as physiotherapy reviews and instruction around prevention in care plans are implemented. |
| 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 Low | The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. Not all incident forms sampled demonstrate registered nurse follow up. The incidents forms are then reviewed and investigated by the manager who monitors issues. If risks are identified these are also processed as hazards. Incidents are trended monthly and a report is reported to the staff meetings. Discussion with the service indicates that management are aware of and are able to describe their statutory requirements in relation to essential notification. |
| 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. | PA Low | There are job descriptions available for positions that describe staff roles, responsibilities and accountabilities. All staff have employment documentation including employment contracts, job descriptions, interview records, reference checks and current visas where applicable. The practising certificates of RN’s are current. The service also maintains copies of other visiting practitioner’s certification. Orientation and training records are documented in each of the five staff files sampled.  There is an annual appraisal process in place and appraisals are current in all staff files reviewed.  Newly appointed staff complete an orientation that was sighted in all files reviewed. Interviews with healthcare assistants described the orientation programme that includes a period of supervision. Supervision can be extended if needed. The service has a training policy and schedule for in-service education that is implemented and external training is available for registered nurses. Interview with staff inform there is access to sufficient training. Training has not occurred in all required areas. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Healthcare assistants reported that staffing levels are now satisfactory. All residents and family members interviewed stated that there were adequate staff and there had been improvement with the new manager and increased stability of staff.  There are two RN's plus clinical manager and facility manager (an RN) on am shifts, two RN's on pm shifts and at night. |
| 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 | Regular medications are dispensed in robotic sachets. An RN checks the regular medications on delivery. All medications are stored appropriately and the storage meets legal requirements and guidelines. RNs complete annual medication competency to administer medications. There is one self-medicating resident who does not have a current competency assessment. This is a previously identified shortfall that continues to require addressing.  As required’ (PRN) medications are dated and timed on administration on the signing sheet. There are special instructions for medication administration as required with the medication charts.  Nine of nine medication charts sampled had photo identification and allergies/adverse reactions noted. One resident does not have a medication chart. Improvement also continues to be required around medication administration.  D16.5.e.i.2; All nine medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | An external contractor is contracted to provide meals. All meals are prepared and cooked on-site. There is a four week menu cycle in place that can be adapted to feedback received from residents and preferences. The menu has been reviewed by a dietitian. Dietary information forms are completed on resident admission and reviewed six monthly with copies held in the kitchen. The chef is informed of any dietary changes. Dislikes are accommodated with alternative choices offered. Special diets are provided. The chef is responsible for ensuring fortified foods are prepared for residents on the REAP programme. Lip plates and specialised utensils are provided for residents to promote independence at meal times. Fridge and freezer temperatures are taken and recorded daily in all areas. All foods sighted in fridges, freezers and the pantry is suitably stored.  Snacks are readily available for residents as required outside of kitchen hours.  D19.2; Staff have been trained in safe food handling and hygiene. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition alters, the registered nurses initiate a review and if required, GP consultation. Four relatives interviewed confirm they are kept informed of any changes in their relative’s health.  Staff interviewed state they have all the equipment referred to in care plans necessary to provide care. Continence products are available and resident continence management plans are completes for residents as applicable.  D18.3 and 4; Dressing supplies are available and there are adequate supplies of other medical equipment. Wound assessments and treatment plans are in place for 20 wounds and timeframes for the next review is documented. These are improvements since the previous audit. Seven have been reviewed in the stated timeframes. This issue was identified at the previous audit and continues to require improvement.  Resident weight is recorded on admission and monitored monthly. Weight loss reports are completed for any resident with weight loss. Residents with weight loss are commenced on the REAP (replenish energy and protein – food fortification) intervention therapy. Fluid balance charts are initiated when needed and the two sampled were up to date and accurate. This is an improvement since the previous audit. Resident files sampled, healthcare assistant interviews, the clinical coordinator and one registered nurse interview indicate that residents are reviewed by a registered nurse immediately if there is a change in health status. This is an improvement since the previous audit.  Improvement is required around short term residents having a short term care plan that documents required interventions and all resident’s care plans documenting interventions for all identified needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a two of activity co-ordinators and two healthcare assistants to implement a seven day week activity programme. There is an integrated rest home/hospital activity programme with activities that are rotated to occur in the different lounges. Attendance at activities is voluntary. The activity co-ordinators make daily contact with residents who are unable to participate in activities or choose to stay in their rooms. Community volunteers including a local school visit regularly. There are outings at least fortnightly.  Resident meetings and surveys provide residents with an opportunity to feedback on the activity programme. Residents and the family confirm on interview they are involved in the development of the care plan which includes activities. The activity co-ordinators maintain an individual activity attendance sheet.  D16.5d. The review of the activity plan and care plan occurs at the same time. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial assessments and initial care plans are developed by an RN within 48 hours of admission in four of five files sampled (link 1.3.6.1). The long term care plan is evaluated at least six monthly in four of five resident files sampled (one resident is on short term care). Six monthly evaluations identify if the resident goals have been met or unmet. Care plans are updated with changes as identified in the evaluations.  ARC: D16.3c; Initial care plans are evaluated by the RN within three weeks of admission for four of five files sampled. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service has a current building warrant of fitness and a certificate of public use which expires on 28 February 2015. This is an improvement since the previous audit. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The previous audit identified that the NZ Fire Service had not approved an evacuation scheme. This has been addressed and there is now an approved evacuation scheme. |
| 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 monitoring is the responsibility of the infection control coordinator. The surveillance activities at Amberlea are appropriate to the acuity, risk and needs of the residents.  The infection control coordinator enters infections on to the infection register and carries out a monthly analysis of the data. The analysis is reported to the staff meeting and the RN meeting. The infection control coordinator uses the information obtained through the surveillance of data to determine infection control education needs within the facility. GP's are notified if there is any resistance to antimicrobial agents. There is evidence of G.P involvement and laboratory reporting. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Staff were familiar with the policy and the definition of enablers. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective.  The restraint manual determines that enablers are voluntary and the least restrictive option. There is no restraint and one enabler in use in the facility. The use of the enabler is voluntary but not included in the care plan (link 1.3.6.1). |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | There is a section on the incident form to document that family have been informed. Family contact is also documented in progress notes and family contact records. Eight incident/accident forms were viewed and three document family contact following the incident. | On five of eight incident forms reviewed, it was not documented that family had not been informed following the incident. | Ensure family are informed of incidents and this is documented.  90 days |
| Criterion 1.2.4.3  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. | PA Low | When an incident occurs the staff member finding the incident writes an incident form. This is then given to the registered nurse for follow up as reported by caregivers and registered nurses interviewed. However the follow up is not always documented. | Four of eight incident forms reviewed did not have documented registered nurse follow up. | Ensure all incident forms identify registered nurse follow up.  60 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 | There is a training plan for 2015 and there has been regular training provided over the last two years. In 2014 there had been training around manual handling (eight attended), hoist training(four attended), cultural safety(five attended), incontinence(five attended), depression(four attended), medications(nine attended), Urinary tract infections(10 attended), consumer rights/informed consent( six attended), quality health and safety, infection control( 19 attended), fire drill (15 attended) and standard precautions (13 attended). | There had been no training around abuse and neglect, chemical safety and food safety in the last 2 years. | Ensure training is provided around abuse and neglect, chemical safety and food safety.  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 | Medications are stored and administered from the two medication/treatment rooms and there is a trolley for each. Sachets are used and are supplied fortnightly and these are checked for accuracy by the night registered nurse. The lunch time medication round was partially witnessed with appropriate practices observed. | (i) One resident has no medication chart, no photograph and no allergies documented. (ii) Four of ten medication charts sampled have regular medications that have not been signed as administered. | (i) Ensure all residents have a medication chart that includes documented allergies and a photograph. (ii) Ensure medications are administered as prescribed.  60 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There is one resident who self-administers medicines. The resident was interviewed and is aware of appropriate processes around the management of their medications and medicines in the room are stored securely. | The resident who self-administers does not have a current competency assessment. | Ensure all residents that self-administer medicines have a competency assessment to do so.  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 Moderate | Monitoring records are kept for pain management, food intake, fluid balance and regular turns. Pain management and food and fluid intake forms sampled show appropriate care provided.  Weights are recorded monthly with referral to a dietitian input and referral to the REAP programme where there has been weight loss..  There are 20 wounds including one pressure area. Short term care plans are completed for wounds and each wound has a detailed assessment and management plan, which are updated as required. The wound review form documents as part of the record of the review when the wound should next be reviewed. | (i) One resident recently admitted does not have an initial care plan that outlines required interventions. (ii) Four of four care plans sampled (two rest home and two hospital) do not have interventions documented for all identified needs. (iii) Thirteen of 20 wounds have not been reviewed within stated timeframes. | (i) and (ii) Ensure all residents have a care plan that documents interventions for all identified needs. (iii) Ensure wounds are reviewed within stated timeframes.  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.

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End of the report.