# Johnsonvale 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](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:** Johnsonvale Home Trust Board

**Premises audited:** Johnsonvale Home

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 9 March 2015 End date: 10 March 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:** 59

# 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

Johnsonvale Home Trust is certified to provide hospital and rest home level care for up to 65 residents. On the day of audit there were 59 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

Johnsonvale Home Trust is governed by a board of trustees and managed by an experienced clinical operations manager. She is supported by a quality development manager and education coordinator. A quality programme and risk management system continues to be implemented with policies in place to guide appropriate quality care for residents. An induction programme and education plan is in place that provides staff with appropriate knowledge and skills to deliver care

The service has addressed five of seven shortfalls from their previous certification audit around cultural training and cultural intervention in care plans, resuscitation status, aspects of care planning, medication administration and storage and chemical safety.

Further improvements continue to be required around self-medication, pain and challenging behaviour assessments including respite care assessments.

This audit also identified an improvement around interventions and evaluations.

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

Family are informed when the resident health status changes. There is a documented process for making complaints and residents, family and staff interviewed were able to discuss the complaints process. Complaints are recorded on a register that includes the complaint, action taken and sign-off within the required timeframes.

## 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. |

Johnsonvale is implementing a quality and risk management system that supports the provision of clinical care. Key components of the quality management system and quality performance link to a number of meetings including health and safety, infection control, quality and clinical meetings. Annual resident and relative satisfaction surveys are completed and results are fed back to the participants.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an annual education plan covering relevant aspects of care and support and external training is supported. The staffing policy aligns with contractual requirements and includes skill mixes.

There is an improvement required around reporting of bruises, job descriptions and performance appraisals.

## 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. |

Residents were assessed prior to entry to the service. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs.

Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme.

Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## 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. |

Johnsonvale home has a current building warrant of fitness which expires on 31 May 2015.

## 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. |

The service has policies and procedures to appropriately guide staff around consent processes and the use of enablers. There are currently no residents using restraint or enablers. Staff receive training in restraint and managing challenging behaviour as part of the annual training plan.

## 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. |

There is an infection control policy that includes surveillance activities. Infections are reported and collated monthly. Infections and internal audit outcomes are discussed as part of the infection control committee meetings. Information is available to staff. The surveillance programme is appropriate to the size and complexity of the facility.

## 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 | 16 | 0 | 2 | 3 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 3 | 3 | 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 | Six resident files sampled identified advance directives were in place and all were appropriately signed. The advance directive includes the resident’s wishes in the event of a cardiopulmonary respiratory (CPR) arrest, illness and special requests in dying and death. The previous finding has now been addressed. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | There is a complaints policy to guide practice. The clinical operations manager leads the investigation and management of complaints (verbal and written). There is an up to date complaints register. There are two complaints for 2015 that are seen to have been investigated appropriately and managed in line with the Health and Disability Commissioner Code of Rights. Complaints are discussed at the quality/staff meetings. Complaints forms are visible around the facility. There is a suggestions box in the main entrance. Discussion with eight residents (five rest home and three hospital) and one relative (hospital) confirm they are aware of how to make a complaint.  D13.3h. a complaints procedure is provided to residents within the information pack at entry |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | Treaty of Waitangi and cultural safety training was provided for staff in November 2014 and another session is scheduled for April 2015. All staff receive written information on the Treaty of Waitangi and cultural safety in the orientation booklet. The care plans of Maori residents were sampled and identify cultural preferences, goals and interventions to meet the resident’s cultural needs. The previous finding has been addressed. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Twelve incident forms were reviewed from January 2015 period. All accident/incident forms evidence family have been informed of an accident/incident. Interview with two registered nurses (RN) and four caregivers confirm family are notified following changes in health status. Quarterly Johnsonvale Journal newsletters for family/residents provide on-going information and updates on services provided.  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: Relative (one hospital) stated that they were informed when their family members health status changes. D11.3: The information pack is available in large print and 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 | Johnsonvale Home Trust provides rest home and hospital level of care for up to 65 residents. There are 25 rest home beds, 25 hospital beds and 15 dual purpose beds. On the day of audit there were 26 rest home residents (two under medical component of their certification and two younger persons) and 33 hospital level residents.  The service is governed by a Board of Trustees and is managed by a clinical operations manager (COM) who is a registered nurse and has been in the role for two and a half years. She is supported by a quality development manager (RN) who was appointed 20 months ago and has eight years experience in aged care. The business plan is reviewed at the end of each financial year (31 April). The business plan and quality goals are due to be approved by the board at the next quarterly meeting. The COM provides a written report to the board.  ARC,D17.3di (rest home), D17.4b (hospital), the COM has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital. |
| 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 | The organisation has a strategic direction that has been communicated to staff. The 2014 business plan and annual quality and risk plan has been reviewed. Policies and procedures are being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. New/reviewed policies are discussed at staff meetings (minutes sighted).  Quality matters are managed through a number of committees including health and safety, infection control, and quality. Meeting minutes demonstrate key components of the quality management system are discussed including internal audit, infection control, incidents (and trends), concerns/complaints. The quality development manager completes monthly analysis of quality data which is submitted for external benchmarking. Johnsonvale is implementing a reviewed internal audit programme. Corrective action procedure forms have been developed to ensure issues arising from internal audits are followed up, recorded and closed off. Four caregivers and two RNs interviewed were able to describe the quality system and how they receive information in respect of quality matters.  Annual resident/relative surveys are undertaken, collated and results fed back to staff, residents and family at meetings held by an independent advocate.  D19.3: There is a comprehensive H&S and risk management programme in place including policies to guide practice. There is a current hazard register. The service has completed a self-assessment for accreditation (ACC) and awaiting an audit date.  D19.2g: Fall prevention strategies are in place that includes the analysis of falls incidents and the use of sensor mats, electric beds, ultra-low beds, hip protectors and physiotherapy assessments post falls. The service has assigned a staff member on duty to supervise high risk residents in the lounge to reduce the number of falls. |
| 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 | D19.3c: The service collects incident and accident data and reports aggregated figures through the health and safety committee and quality/staff meetings. Incident forms are completed by staff. The RN reviews and assesses the resident at the time of event and the form is forwarded to the COM for follow-up and sign off (link 1.3.6.1). Twelve incident forms were reviewed and were seen to have been completed and closed off. Incidents/accidents were recorded in the progress notes. There is an improvement required around the reporting of bruising.  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 processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resources policies to support recruitment practices. A list of practising certificates is maintained. Six staff files were reviewed. There is an improvement required around job descriptions and annual performance appraisals.  The service has updated its orientation booklets and these are now role specific (RN/EN, caregiver and domestic staff). All booklets contain a generic induction that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed believed new staff were adequately orientated to the service.  The services employs an education coordinator/career force assessor for 16 hours a week. There is an annual education plan that includes the required education as part of these standards. The plan is being implemented. There is evidence that additional training opportunities are offered to staff such as attendance at external clinical seminars. InterRAI training is in progress for RNs’. A competency programme is in place that includes annual competency for medication, health and safety, infection control and restraint. A record of training is maintained with content of education, attendance list and session feedback forms. The service has identified low attendance at some compulsory training. Staff were surveyed to identify the best time of day for education. Two sessions are now offered for staff which has increased staff attendance numbers. Staff interviewed are aware of the requirement to complete compulsory training.    There is a staff member with a current first aid certificate on every shift. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There are policy, procedures and guidelines that align with contractual requirements and includes skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Residents and relative confirm there are sufficient staff on duty at all times. There is a registered nurse on duty 24:7. On morning duty there is either two RNs or one RN and an enrolled nurse. Agency caregivers are currently being used to cover unexpected caregiver leave. |
| 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 service uses individualised medication blister packs which are checked in on delivery. Two registered nurses were observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. Resident photos and documented allergies or nil known were on all 10 medication charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted.  There was one resident who self-administered medications (inhalers) without a self-medication competency in place. The previous finding remains. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All medication charts reviewed recorded indication for use of as required medication by the GP. As required medication was reviewed by a registered nurse each time prior to administration. Medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed. Previous findings in relation to monitoring the medication fridge temperature and as required medication have been addressed. |
| 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 | All meals at Johnsonvale and prepared and cooked on site. There is a five weekly seasonal menu with dietitian review and audit undertaken in January 2015. Meals are prepared in a kitchen adjacent to the main dining room for serving. Cooks and kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for to promote independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses. A dietitian is available via referral to review residents. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by the dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission which forms the basis of resident goals and objectives. Assessments are reviewed at least three monthly for all permanent residents. There is an improvement required around assessments for respite residents. Appropriate risk assessments had not been completed for individual residents with identified pain and behaviour issues. The previous finding around pain and challenging behaviour assessments remains open. Falls risk assessments were completed and the previous finding around falls assessments has been addressed. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The care plan of an insulin dependent diabetic included a diabetes management plan. Short term care plans were sighted for short term needs. Residents/relatives (interviewed) confirm they are involved in the care planning process. This is evidenced by their signature on the care plan form. |
| 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 | A written record of each resident’s progress is documented. Changes are followed up by a registered nurse (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Shortfalls were identified around documentation. Dressing supplies are available and treatment rooms were well stocked for use. Wound documentation was reviewed and included wound assessment, treatment plans, evaluations and progress notes for all wounds. Documentation did not reflect that dressing changes met the required timeframes. Advised that wound care nurse specialist advice is readily available. Continence products are available and specialist continence advice is available as needed. Short term care plans with interventions and on-going evaluations by the RN were evidenced. A physiotherapist referral is initiated if required and assessment of any equipment needed. |
| 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 activities staff provided an activities programme over five days each week. There is a volunteer who leads a reading group on Sundays. The service is actively recruiting for a Saturday activities co-ordinator. The programme is planned monthly and residents received a personal copy of planned monthly activities. Activities planned for the day were displayed on notice boards around the facility. A diversional therapy plan was developed for each individual resident based on assessed needs. Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that was used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Long term care plans evidenced written evaluations with a six monthly multidisciplinary (MDT) care plan review involving the RN, activities staff, caregiver, and family members. Short term care plans were evaluated and either resolved or any on-going problem added to the long term care plan. |
| 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 facility displays a current building warrant of fitness which expires on 31 May 2015. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Random checks of the laundry and sluice room identified the laundry was locked and the sluice room door was kept closed. The previous finding around safe chemical storage has been addressed. |
| 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 surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (clinical operations manager) uses the information obtained through surveillance to plan and determine infection control activities, resources, and education needs within the facility. All infections are entered onto a monthly infection analysis form. A monthly report is completed by the infection control co-ordinator, which is distributed to the infection control committee and relevant meetings. Johnsonvale participates in an external benchmarking programme that includes infection rates. There is close liaison with the GP that advises and provides feedback /information to the service. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. There are no enablers or restraints in use. The clinical operations manager is the restraint coordinator. Annual training in restraint and challenging behaviour is provided. Staff complete a restraint competency. Restraint/enablers are discussed at the clinical meetings. |

# 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 1.2.4.3  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 | D19.3b; The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered. Progress notes record incidents/accidents including bruising (also link 1.3.6.1). | There was no evidence of an incident/accident form for one hospital resident with two reports of bruising as per the progress notes. | Ensure all incidents/accidents are reported on incident/accident form.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | The six staff files sampled contained recruitment documents including letters of appointment, reference checks, qualifications and employment agreements. Three of six staff files included a signed job description. | Three of six staff files did not include a signed job description | Ensure all staff files contain a signed job description.  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 | There is a 2015 training analysis planner. Staff provide input into the planner through discussion at meetings and the post education session feedback forms. The performance appraisal system identifies education needs on an individual basis. All caregivers have had an appraisal this year. There is an improvement required around annual appraisals for other staff. | Three of six staff files sampled did not have an annual appraisal completed | Ensure appraisals are conducted annually.  90 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | There is a self-medicating resident’s policy and procedures in place which requires all self-medicating residents to have competency assessment completed by the GP. There was one resident who self-administers medications (inhalers) without a self-medication competency in place. | The one self-medicating resident did not have a competency assessment completed by the GP. | Self-medicating competency to be completed and current for all self-medicating residents.  30 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | Risk assessments are being completed for continence, pressure area and falls as applicable. Assessments for pain, challenging behaviour and for respite care residents are required as per policy. | (i) Assessments were not undertaken for a respite resident on admission. (ii) There was no challenging behaviour assessment or monitoring for resident with known challenging behaviours; (iii).There were no pain assessments completed on admission for five of five residents who identified as having pain. | (i) Ensure risk assessments and initial care plans are completed or updated for all respite admissions. (ii) Residents exhibiting or having a history of challenging behaviour to have behaviour assessments and monitoring documented; (iii) All residents with identified pain to have pain assessment undertaken on admission.  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 | LTCPs, short term care plans and wound management plans were in place are utilised by staff to guide them in care needs and timeframes. Resident falls were recorded in progress notes and incidents communicated to the staff at handover. | i).Monitoring chart for a resident with challenging behaviours does not “regular 60 minute checks day and night” as directed in the resident’s LTCP. ii) There were no interventions documented to support management of short term memory loss for the respite resident or management of warfarin. iii).Ten of ten wounds not documented as managed within the assessed timeframes. iv) Neurological observations had not been completed for two residents post fall with head injury. | i) and ii).Ensure interventions are documented to reflect residents current health status. iii).Wound management timeframes to be met for all wounds.  iv) Ensure neurological observations are completed post head injury.  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.