

Cantabria Home and Hospital Limited

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group 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:	Cantabria Home and Hospital Limited
Premises audited:	Cantabria Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Intellectual; Residential disability services - Physical
Dates of audit:	Start date: 15 July 2015 End date: 16 July 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:	154

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Cantabria Home and Hospital (Cantabria) is one of three facilities owned and operated by the same provider. It provides hospital, rest home, intellectual and dementia level care for up to 258 residents.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, family/whānau, management and staff. No GP was available on the days of audit.

One area identified for improvement from the previous audit related to corrective action documentation has been addressed. There are ten new areas identified for improvement related to complaints management, quality and risk, continuum of service delivery, and restraint minimisation.

Feedback from residents and family/whānau members was positive about the care and services provided.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Communication with residents is open and honest, reflective of the service's open disclosure policy. The service implements processes for contacting interpreting services when this is required.

The service has policy and procedures in place which identify how complaints are to be documented, reviewed, followed up and addressed; however not all processes are followed and this needs to be addressed.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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At Cantabria the governing body ensures that business and strategic planning are in place, covering all aspects of service delivery, and show how services are planned and coordinated to meet residents' needs. Goals are identified and reported against at senior management level.

Service delivery is overseen by a nurse manager who has been in the role for four weeks but has worked for the organisation as a nurse manager at another facility for over four years. She is qualified for the role she undertakes and supported by a group of both clinical and non-clinical managers.

The service has quality and risk management systems in place covering all aspects of service delivery. Quality management reviews include an internal audit process, complaints management, resident and family/whānau satisfaction surveys and incident/accident and infection control data collection. Inconsistencies sighted related to recording and reporting of audit results. Documented quality and risk management activities results are shared among staff and residents as appropriate. Not all incident and accidents are reported using identified processes and this needs improvement.

The day to day operation of the facility is undertaken by staff who are appropriately experienced, educated and qualified. As confirmed during residents and families/whānau interviews and in the satisfaction survey results, residents' needs are met.

The service implements documented staffing levels to ensure contractual requirements are met and to meet residents' needs.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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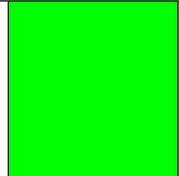
The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The organisation has implemented the required electronic assessment tool and implements interventions to achieve the resident's desired outcomes and goals. There are a number of areas related to documentation and updating of assessments, care plans and evaluations that require improvement to meet the standards and contractual requirements.

The service provides a planned activities programmes. For the rest home and hospital residents the activities are planned and provided to develop and maintain skills and interests that are meaningful to the resident. There were shortfalls noted in the activities provided in the dementia unit and for the younger residents living at the service.

There are improvements required to the medicine management system. Processes and procedures around storage, medication charts and ensuring ongoing staff competence require improving to reflect legislation and current best practice.

The service is able to meet all identified nutritional requirements for residents. Residents' likes, dislikes and special diets are catered for, with food available 24 hours a day. The service has a five week, summer/winter rotating menu which is approved by a registered dietitian.

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.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
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There are five restraints and two enablers in use at Cantabria at the time of audit. Policies and procedures reflect current good practice and meet legislative and Health and Disability Services Standard requirements. Enablers are described as voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education programme, with attendance monitored.

The information sighted in the restraint register does not allow a complete auditable record and this needs improvement.

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.
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There is a monthly surveillance programme, where infections are collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff 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	7	0	6	3	0	0
Criteria	0	29	0	7	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Moderate</p>	<p>The service has a complaints register which identifies the issue, the dates received, dates reviewed and closed and the actions taken to resolve the complaint. However not all complaints are shown in the register and this is an area identified for improvement.</p> <p>There is a Health and Disability Commissioner (HDC) complaint open. The complaint was first registered in February 2015 and the service has responded to all questions to date. A letter from HDC states a decision is yet to be made related to the complaint proceeding. Management confirmed complaints management information is used as an opportunity to improve services. The service has recently employed a complaints liaison person (RN) so that complaints can be better addressed.</p> <p>Management, resident and family/whānau interviews, confirmed that complaints management was explained during the admission process. Staff verbalised their understanding of the need to document all complaints. There was some confusion among staff as to the process to following when addressing a complaint. Some complaints which have been dealt with have remained at unit level and not been forwarded to the nurse manager and therefore not all information has been captured in the complaints register. The nurse manager will address this via staff</p>

		<p>memos and ongoing education. Complaints are a standing agenda item for both management and staff meetings as confirmed by meeting minutes sighted.</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>The families of residents interviewed confirmed that they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure is documented in the family communication sheets, on the accident/incident form and in the residents' progress notes.</p> <p>The service promotes an environment that optimises communication through the use of interpreter services as required and staff education related to appropriate communication methods. Some residents do not have English as their first language, with effective communication being maintained by staff and family/whanau who speak the resident's language. Policies and procedures are in place if interpreter services need to be accessed.</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>Cantabria has an up to date business plan which is reflective of organisational goals and direction. Each goal is discussed and reported against at monthly senior management meetings which one or more of the owners attend. Senior management meetings are used to ensure the services offered are coordinated and meet residents' needs. Monthly reports sighted from all areas of the service are reviewed during these meetings as confirmed in meeting minutes sighted.</p> <p>On the day of audit there were 98 rest home, 46 hospital and 10 dementia level care residents at the facility. (Seven rest home and four hospital level care residents are under the age of 65).</p> <p>The nurse manager is a registered nurse and has been in her role at Cantabria for four weeks. She is conversant with all systems as she worked at another facility run by the Cantabria group as a nurse manager for four years. She maintains her education to a level required for the role she undertakes. The nurse manager's job description identifies her authority, accountability and responsibility for the provision of services. The organisation's operational manager represented the organisation on the days of audit.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service. This is supported by the 2015 resident and family/whanau satisfaction survey results sighted.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>All staff have access to the quality and risk management system documented in policy. Policies and procedures are maintained at organisational level which identify interRAI requirements.</p> <p>Quality systems cover incident and accident reporting, health and safety reporting, infection control and restraint minimisation data collection and complaints management. Data collected is collated, reviewed and benchmarked against previously collected data and with the other two facilities in the group. Results are discussed at staff and senior management meetings. This is confirmed in meeting minutes sighted and during management and staff interviews. Corrective actions are put in place to address any identified deficits and an improvement required from the previous audit is fully addressed; however, the reporting system for planned audits is inconsistent.</p> <p>Actual and potential risks are identified and documented in the hazard register. The health and safety committee oversee all newly found hazards and they ensure they are communicated to staff and residents as appropriate. This was shown in the meeting minutes sighted. Staff confirmed that they understood and implemented documented hazard identification processes.</p> <p>Resident and family/whānau members interviewed confirmed they are happy with the services provided. Staff are able to verbalise quality improvements and how they have been embedded into everyday practice, such as a newly developed project being undertaken to reduce falls (the 'Intentional rounding project'). There is no data to date to show the outcome of this improvement as it has only been in place two weeks.</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>	<p>PA Moderate</p>	<p>Policy identifies that accidents, incidents and near misses must be recorded and reported to management accurately, in a timely manner. Staff interviewed stated they understood the required process. The completed incident and accident forms sighted identify corrective actions are put in place as required; however not all incidents and accidents recorded in residents' files had a corresponding incident and accident form.</p> <p>Data collected from incidents and accidents is reviewed at each staff meeting and information details show any common trends, such as time of day. The health and safety committee review incident and accident forms to ensure corrective action</p>

		<p>outcomes are in place to assist a positive outcome.</p> <p>The nurse manager and the operations manager fully understood the obligations in relation to essential notification.</p> <p>Family/whānau interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. This is supported during a review of resident incident and accident forms.</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>	FA	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Upon employment, referees are contacted and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles, which are repeated annually, as confirmed during staff files reviewed.</p> <p>Staff undertake training and education related to their appointed roles. Annual appraisals are up to date. The education calendar is set at organisational level with additional 'tool box' education being presented at staff meetings. Staff education includes regular on site education with guest speakers, off-site seminars and training days covering all aspects of service delivery. This was confirmed in the education records sighted for 2014-2015.</p> <p>Not all staff who are required to administer medications have a current competency. The human resources department have a list showing how this is being managed. (Refer comments in criterion 1.3.12.3).</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted. Care assistants who work in the dementia care unit hold appropriate specific qualifications.</p> <p>Resident and family/whānau members interviewed, along with the 2015 satisfaction survey results, identified that residents' needs are met by the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	FA	<p>Organisational policy identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe quality care. Rosters are analysed at head office to ensure staffing numbers match residents' level of care needs</p>

<p>experienced service providers.</p>		<p>according to safe staffing level guidelines for aged care. Cantabria have a new electronic system in place which analyses staffing rosters to ensure all staff who are allocated to work in the secure dementia unit hold specific dementia qualifications and that each area of service has a staff member who holds a current first aid certificate. There are at least two RNs at the facility at any given time.</p> <p>A review of four weeks rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated all their needs have been met in a timely manner.</p> <p>There are dedicated activities, kitchen, laundry and cleaning staff. (Refer comments in criterion 1.3.7.1 related to activities).</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medicines are individually supplied for each resident by the pharmacy in a pre-packed administration system for most residents. In the hospital section some medications are bulk supplied (such as paracetamol). The medicines and medicine signing sheets are checked for accuracy by the RN when delivered. The GP conducts a medicine reconciliation on admission to the service and when the resident has any changes made by other specialists.</p> <p>The medicines and medicine trolley were securely stored. Medicines fridges are in most areas of the service. The dementia unit stored medications that require refrigeration in the kitchen fridge. It is noted that there is one medication in the fridge required to be discarded after 14 days, though there was no date recorded when the medication was opened.</p> <p>There were no controlled drugs are stored in one wing of the hospital and one wing in the rest home. The controlled drug registers records two staff sign out the medications at each administration, at weekly checks and the at least six monthly quantity stock count. The service have a separate medication folder for controlled drugs, which is being phased out, as this current system is not reflective of best practice (refer to 1.3.12.1).</p> <p>All the medication files sampled in the electronic record had prescriptions that complied with legislation and aged care best practice guidelines. The medicine review date is recorded in the electronic records, with all residents having their medicines reviewed within the last three months.</p> <p>Medication competencies were not sighted for all staff who assist with medicine</p>

		<p>management.</p> <p>The staff reported that there were no residents who self-administer medicines. The service has policies, procedures and self-administration guidelines to assess if a resident was competent to administer their own medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>A five week rotating menu with summer and winter variations, has been reviewed by a dietitian in April 2013 and reviewed in June 2014 by the organisation. The kitchen staff receive a copy of each resident's nutritional profile, which includes the resident's nutritional needs, wants, dislikes upon admission. Not all dietary profiles sighted in both the hospital and rest home kitchen are up to date. Policy requires these to be updated as part of the six monthly assessments. (Refer to comments in 1.3.6.1).</p> <p>Special diets are catered for. A summary of any special diet is recorded and displayed in the kitchen for staff to use as a reference when catering for meals. There is food and nutritional snacks available 24 hours a day. The residents and family/whānau report they are satisfied with the food and fluid services. Residents' file reviews identify interventions are put in place to address any weight variations, such as dietary supplements, dietitian visits as indicated, and regular weight monitoring.</p> <p>The kitchen process complies with current legislation and guidelines. Fridge and freezer recordings sighted met food safety requirements. The kitchen staff have undertaken food safety education.</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>	PA Low	<p>All the care plans reviewed record interventions. The three hospital level files reviewed (including one of the younger residents) have clear and individualised interventions documented. There are improvements required in the documenting of interventions on the care plan for the rest home and dementia level of care residents.</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</p>	PA Low	<p>The rest home and hospital level residents and family whanau reported satisfaction with the range and variety of activities provided. There is scope for ongoing implementation and improvements to the activities provided for the younger</p>

<p>their needs, age, culture, and the setting of the service.</p>		<p>residents and residents living in the dementia unit (refer to 1.3.7.1). The rest home and hospital residents were observed to be participating in meaningful age appropriate activities for the older person. The diversional therapist reported the activities are modified according to the capability and cognitive abilities of the resident, with examples given of how activities have been modified for residents with sight and vision impairment, and physical disabilities. The activities programme covered physical, social, recreational and emotional needs of the residents. There was diversional therapy, activities, social and cultural assessments sighted in the rest home and hospital residents' files reviewed.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>The evaluations are recorded on the care plan in all files reviewed. The three files in the hospital service do not have the evaluation recorded in the last six months (refer to 1.3.3.3). Evaluations in the rest home and dementia level of care files described how the resident is progressing towards meeting their goals. Where progress was different from expected the service uses short term care plans to identify and record these temporary needs. If the change is ongoing, this is recorded and updated on the long term care plan. Short term care plans were sighted in the all the files reviewed. Though short term care plans were sighted in the files reviewed, some temporary changes were not recorded after follow up from incidents and accidents.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Documentation identifies all processes are maintained for the facility's current building warrant of fitness. There have been no changes made to the building footprint since the previous audit.</p>
<p>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.</p>	<p>FA</p>	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity of services offered at Cantabria, including dementia care, as shown in the infection control programme. All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is clearly described in the quality plan and management meetings and describe actions taken to ensure residents' safety.</p> <p>The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease and actions taken to reduce infections. The</p>

		analysis includes the feedback that is provided to staff. The management and staff meetings recorded actions that are implemented to prevent and reduce infections. The data reviewed records that infections have reduced over the past three months.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	PA Low	<p>The restraint minimisation policy identifies that the use of enablers are voluntary and the least restrictive option to meet the needs of the resident.</p> <p>Cantabria have two enablers and five restraints in use at the time of audit. This is confirmed during interviews with staff and the restraint coordinator. Staff confirmed they understand the requirements for both restraint and enablers. Information in the restraint register was inconclusive and could not be used to verify restraint numbers.</p> <p>Staff education is undertaken as part of the orientation and annually thereafter to ensure staff knowledge is up to date should restraint be put in place.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>The service has a complaints register which contains information related to reported complaints. The newly appointed nurse manager was aware that not all complaints were being treated in the same manner and that policy was not being met. She has commenced education to staff to ensure all reported complaints are documented and acknowledged in a timely manner, reviewed, investigated and written in the complaints register which is kept in the nurse manager's office. Follow up actions undertaken are identified for complaints completed. One complaint made to the Health and Disability Commissioner remains open.</p>	<p>Not all complaints are reported using the process identified in policy. Two complaints sighted have not been investigated through the correct channels. Both the complaints mentioned have been dealt with at a unit level only. In one case all follow up is shown in the resident's file but in the second case no corrective actions are shown.</p>	<p>Ensure all complaints are recorded in the complaints register and that policy requirements are met.</p> <p>90 days</p>

<p>Criterion 1.2.3.5</p> <p>Key components of service delivery shall be explicitly linked to the quality management system.</p>	<p>PA Low</p>	<p>Regular reporting of key components of service delivery occurs for event reporting, complaints management, infection control, health and safety and restraint minimisation. Corrective actions sighted for deficits identified included 'crock pots' being used to serve breakfast porridge to ensure it remains hot.</p> <p>The service has a documented annual audit plan which covers all areas of service delivery. Policy states that audits are to be completed and results then go to the nurse manager who reports them monthly at senior management. Corrective actions should be reviewed by the quality group three monthly. This process does not always occur. For example, some audits are being followed up at unit level or by an area manager and therefore this information does not get recorded accurately or monitored by the quality group as required. The nurse manager is aware not all procedures are being followed and is currently addressing the situation via staff education.</p>	<p>The audit plan indicates the staff member responsible for undertaking each audit. There is inconsistency in how audit results are reported and recorded. Not all audit results are reported to the nurse manager as required in policy. This has resulted in fragmentation of audit result reporting and review process.</p>	<p>Ensure audit results and report occurs to meet policy requirements so reporting is accurate.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to</p>	<p>PA Moderate</p>	<p>One resident's file review identified that following a fall, resulting in the resident being hospitalised for treatment, there is no incident and accident form completed. Actions</p>	<p>The recording and reporting of adverse events sighted identified that the service undertakes corrective actions to improve service delivery and manage risk. Not all</p>	<p>Ensure all adverse, unplanned or untoward events are documented to meet policy requirements and that</p>

<p>improve service delivery, and to identify and manage risk.</p>		<p>taken are recorded in the resident's progress notes. One incident and accident form identified a corrective action which is not identified on the resident's care plan. (Refer comments in criterion 1.3.3.3). A one page log of incidents and accidents is kept in each resident's file but information is not always kept up to date.</p>	<p>incidents and accidents have a corresponding incident and accident form completed. Incident and accident forms are kept in a separate file.</p>	<p>reporting requirements are accurate.</p> <p>90 days</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>There were medications that are required to be discarded after 14 days of opening with the date that the medication was opened not recorded.</p> <p>The service has an extra folder for the administration of controlled drugs. This folder has a copy of the resident's medication chart for the staff to administer from; not all these medication charts or copies of charts are reviewed within the last three months. It was not able to be established if these charts are the resident's most current chart or prescription.</p> <p>One medication chart had paracetamol charted above the recommended dose.</p> <p>There is bulk supply of some medications in the hospital wings, though there are a number of rest home residents who live in these sections. It was unclear if the bulk supply of medications were only given</p>	<p>Not all medications that require documenting when opened record when the medication was opened (eg, antibiotics). The separated controlled drugs charts do not reflect best practice. Not all medication prescriptions reflect current best practice.</p>	<p>Ensure all medicine management complies with legislation and current best practice.</p> <p>90 days</p>

		to the hospital level of care residents, as all medications for rest home level of care residents are required to be individually prescribed.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	<p>Records evidence that four of the RNs and four of the caregivers who assist in medicine management do not have a current competency assessment. This was being addressed at the time of audit, with one staff member now requiring to demonstrate competence.</p>	<p>Some RNs and caregivers do not have a current medication competency.</p>	<p>Ensure all staff who assist in medicine management have a current medication competency.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>The three hospital level of care residents' files reviewed do not have an evaluation of care recorded in the last six months. All three care plans have been re-written within the last six months and reflect the resident's current needs. Clinical staff interviewed in the hospital area report that they reviewed and evaluated the previous care plan, though this was not documented on the previous or current care plan.</p> <p>The organisational policy on nutritional assessments requires six monthly updating and has not been consistently updated. The rest home files reviewed have nutritional profiles that have not been updated within the last six months.</p>	<p>Three of the nine files reviewed do not have an evaluation documented within the last six months. Seven of the files reviewed do not have a nutritional assessment that has been updated within the last six months.</p>	<p>Ensure all assessments and evaluations of care are documented within the required time frames.</p> <p>180 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>All the care plans reviewed have a care plan that records the issue, goals and interventions. The files reviewed of residents living in the rest home (including a younger resident) and dementia unit are not always individualised to the specific needs of each of the residents. Both the files reviewed of the residents living in the dementia unit have challenging behaviours recorded, though the care plan does do clearly identify what the behaviour is and the specific triggers and de-escalation techniques that work for each of the residents. These are recorded on other formats, such as behaviour assessment tools. Staff in the dementia unit demonstrated knowledge of each of the resident's specific behaviours, what type of situations can trigger the behaviour, and know how to divert the resident when required.</p>	<p>The documented interventions are not consistently recorded to a level of detail that provides clear strategies for each individual resident.</p>	<p>Ensure the documented interventions are consistent with meeting resident's individual needs.</p> <p>180 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>A family member, diversional therapist and staff in the dementia unit reported that there was a period of time from the end of 2014 to March 2015 where minimal planned activities were being conducted in the dementia unit (one hour a day). The diversional therapist reports that since March 2015 they have now have completed all the activities profiles for the residents living in the dementia unit. The family member reported that there is now increased activities in the unit. The</p>	<p>The activities programme is still being developed, with limited aged specific activities provided for the younger disabled residents under the age of 65.</p>	<p>Ensure appropriate age specific activities are provided or facilitated.</p> <p>180 days</p>

		<p>auditor observed the activities coordinator providing activities to residents in the dementia unit at the time of audit.</p> <p>One of the younger people expressed that the programme catered more for the older person and they feel linkage to the community is lacking. One of the other younger persons reported that they go out daily to an external day programme; this resident did express some concerns about this day programme, with this feedback provided to the management team. The diversional therapist reports they are in the process of reviewing the activities programme for the younger people, though this has not yet been fully implemented.</p>		
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Low	<p>From the follow up of some incident forms, short term care plans were not sighted for temporary changes. An example includes a resident with a fracture who does not have these changed needs documented in the short term or long term care plan. One other resident now requires an additional toileting regime; these were not recorded in the long term care plan, short term care plan or quick reference care plan in the residents' rooms.</p>	<p>Not all temporary needs are documented in short term care planning.</p>	<p>Provide evidence that all changes in needs are included in the care planning documentation.</p> <p>180 days</p>

<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>PA Low</p>	<p>Policy states that enablers are voluntary and the least restrictive option to meet the resident's needs. There are two bedside rails in use as enablers and three bedside rails and two chair lap belts as restraints. Residents' files reviewed for restraint use only, identify that all processes are undertaken prior to restraint being put in place. Each unit maintains a list of when restraint reviews are due. The restraint register sighted is not up to date.</p>	<p>The information in the restraint register is very confusing and could not be used to verify restraint and enablers in use. Not all current restraints are shown in the register. It is not documented when restraint commenced or when the next restraint assessment is due.</p>	<p>The restraint register is an accurate, auditable record of all restraint in use.</p> <p>180 days</p>
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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.