# Selwyn Care Limited - Selwyn Park

## 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:** Selwyn Care Limited

**Premises audited:** Selwyn Park

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

**Dates of audit:** Start date: 3 November 2015 End date: 3 November 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:** 84

# 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

Selwyn Park provides rest home, hospital and dementia level care for up to 88 residents and on the day of the audit, there were 84 residents. A village manager/enrolled nurse, a care lead/registered nurse and an assistant care lead/registered nurse manage the service. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the Northland District Health Board. The 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.

The service has addressed three of the four shortfalls from the previous certification audit around the complaints process, business plans, and monitoring residents using restraint. Further improvements are required in relation to adverse events.

This surveillance audit identified that improvements are required around communicating quality and risk information to staff, corrective action plans, care interventions, activity plans in the dementia unit and aspects of medication management.

## 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. |

Evidence of open communication is documented on the accident/incident report and in the resident’s progress notes. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |

The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities are conducted, which generates improvements in practice and service delivery. Resident and family meetings are held. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and investigated. A comprehensive education and training programme has been implemented. Appropriate employment processes are adhered to. A roster provides sufficient and appropriate cover for the effective delivery of care and support.

## 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. |

The registered nursing staff are responsible for each stage of service provision. The assessments, initial and long term nursing care plans are developed in consultation with the resident/family/whānau and implemented within the required timeframes to ensure there is safe, timely and appropriate delivery of care.

The sample of residents’ records reviewed provides evidence that the provider has implemented systems to assess and plan care needs of the residents. The residents' needs, outcomes/goals have been identified in the long-term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the rest home hospital and dementia residents. Spiritual and cultural preferences and needs are being met.

Medication polices reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies.

Food services and all meals are prepared on site. Kitchen staff and those serving the meals know resident’s individual food preferences and dislikes. There is evidence that there are additional nutritious snacks available over 24 hours. There is dietitian review of the menu. All kitchen staff are trained in food safety and hygiene.

## 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. |

A current building warrant of fitness is posted in a visible location.

## 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. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were three hospital-level residents using restraint and no residents using enablers. Restraint management processes are adhered to.

## 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 type of surveillance is appropriate for the size and complexity of the service. Effective monitoring is the responsibility of the infection control coordinator. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within 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 | 12 | 0 | 3 | 2 | 0 | 0 |
| **Criteria** | 0 | 34 | 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 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with residents and families demonstrated their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.  There is a complaints register. Twenty-one verbal and written complaints have been documented for 2015 (year-to-date). All complaints have noted investigation, timeframes and resolutions. Complainants are provided with written information to reflect acknowledgment, investigation and resolution of their complaint. This is an improvement from the previous audit. Complaints are not being collated or analysed with results communicated to staff (link to finding 1.2.3.6).  Corrective actions were not always evident where there were opportunities for improvement resulting from complaints received (link to finding 1.2.3.8).  Discussions with seven residents (four rest home level and three hospital level) and relatives confirmed that any issues are addressed and that 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. | FA | Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.  The incident/accident forms include a section to record family notification. All 10 incident/accident forms reviewed indicated family were informed. Three families interviewed (one rest home level, one hospital level, one dementia level) confirmed they were notified of any changes in their family member’s health status. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Selwyn Park is a purpose built facility that is part of a larger retirement village. The facility provides residential care for up to 88 residents at rest home, dementia and hospital level care. Occupancy on the day of the audit was 44 residents at rest home level care, 26 residents at hospital level care and 14 residents in the dementia unit. There are no dual-purpose beds. There were no residents requiring care under the medical aspect of the contract and two respite residents (one rest home level and one dementia level).  The Selwyn Foundation is a charitable organisation governed by nine appointed board members. There is a 2013 – 2017 organisation-wide strategic plan and a 2015 Selwyn Park business plan that contains site-specific goals and objectives. This is an improvement from the previous audit. Business goals and objectives are regularly reviewed.  The village manager is currently on extended leave. Selwyn Park is currently managed by an experienced village manager/enrolled nurse who has been in the role since June 2015. Prior to this, she was the manager of a rest home. She is supported by a care lead/registered nurse (RN), who has been in the role for three months and has previous experience as a nurse manager and clinical tutor, and an assistant care lead/RN who has been in his role at the facility for one year.  The village manager/EN and care lead/RN have maintained at least eight hours annually of professional development activities related to managing a rest home and 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. | PA Low | A 2015 quality and risk management programme is in place. Interviews with all three managers and staff (three caregivers, six RNs, three activities staff, one clinical educator, one health and safety officer) reflect their understanding of the quality and risk management systems.  Policies and procedures, and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place and policies are regularly reviewed. Policies and procedures are currently being updated to include reference to InterRAI for an aged care service. New policies or changes to policy are communicated to staff, as evidenced in meeting minutes.  Data collected (eg, falls, medication errors, wounds, skin tears, challenging behaviours) are collated and analysed with results posted in the staffroom. Communication of quality results with staff in staff meetings is not evident in the meeting minutes. Corrective actions have been implemented through April 2015 where benchmarked data exceeds targets, but have not been documented from May 2015 onwards. An internal audit programme is in place. Areas of non-compliance include the initiation of a corrective action plan with sign-off by a manager when implemented.  The organisation has achieved a tertiary level ACC Workplace Safety Management Practice (expiry March 2017). The health and safety officer has completed stage one health and safety training, and attends six-monthly health and safety meetings at head office. Health and safety is addressed in the weekly management meetings.  Falls prevention strategies include an investigation of residents’ falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. The facility has purchased sensor mats and two beds that can be lowered to low levels. A falls focus group is in place for the organisation with a facility-specific falls group being organised. |
| 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 | There is an accidents and incidents reporting policy. Adverse events are investigated by the clinical lead and/or registered nursing staff. One accident/incident report failed to reflect adequate neurology observations following a knock to the resident’s head (link to finding 1.3.6.1). The remaining nine accident/incident reports reviewed were completed in full. This previous area for improvement remains.  Adverse events are trended and analysed but results are not consistently communicated to staff (link to finding 1.2.3.6) and corrective actions are not being documented where adverse event thresholds exceed acceptable targets (link to finding 1.2.3.8).  Discussions with the village manager and clinical lead confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. This has not been required. |
| 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. | FA | There are human resource management procedures in place, which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity. Copies of practising certificates are kept. Six staff files were reviewed and evidenced that reference checks are completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2015 is being implemented, which exceeds eight hours annually. Ten caregivers work in the dementia unit. Nine caregivers have completed their dementia qualification and one caregiver employed for less than one year is in the process of completing. The registered nursing staff attend external training in addition to training provided in-house. Five of nine RNs have completed their InterRAI training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A staff rationale and skill mix policy is in place. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse is on site at any one time. Activities staff are available seven days a week. Extra staff can be called-on for increased residents' requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses individualised medication blister packs for regular and ‘as required’ (PRN) medications. Medication reconciliation is completed on delivery of medications and signed off by the RN checking the medications. There are weekly and six monthly controlled drug checks. All clinical staff who administer medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. All RNs have completed syringe driver training. Staff were observed to be safely administering medications, however not all medications were administered according to the prescribers instructions. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Standing orders are in use. The GP and RN had assessed three self-medicating residents as competent to self-administer.  Twelve medication charts sampled (four rest home, four hospital, four dementia) met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. |
| 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 | The meals at Selwyn Park are prepared on site by an external contractor. A four weekly seasonal menu is designed and reviewed by a registered dietitian. The cook receives resident dietary information from the RNs and is notified of any changes to dietary requirements (vegetarian, moulied foods) or of any residents with weight loss. The chef (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for residents with dislikes or religious preferences. Additional nutritious snacks are available for the dementia residents. Additional food and snacks are available over a 24-hour period in the dementia unit.  Food safety management procedures are adhered to, including storage of food and temperature monitoring. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have completed food safety and hygiene courses.  The residents interviewed are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the residents’ meetings and through resident surveys. |
| 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 nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.  Not all resident files reviewed evidenced that interventions were documented for all identified care needs. Monitoring forms were completed as required and evaluated by a registered nurse. An activities plan is completed on admission and reviewed six monthly with the care plan review (link to finding 1.3.7.1).  Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and specialist involvement in wounds/pressure areas. Not all wounds had documented assessments, evaluations with each dressing change or had wound management plans signed by an RN.  Continence products are available and residents’ files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.  The clinical files sampled evidenced involvement of referral to allied health and specialist services as required, including speech language therapist, physiotherapist, dietitian, skin specialist, podiatrist, and wound care specialist. |
| 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. | PA Low | There is one diversional therapist and three activity assistants who provide a programme over seven days per week. The activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. On the day of audit residents in all areas were observed being actively involved in a variety of activities with support and involvement of the care staff. The programme is developed monthly and displayed in large print. The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families. The residents and families interviewed spoke positively about the activities programme.  The programme is comprehensive and includes van outings, walking groups, gardening, pet visits, church services, and art and crafts. There are resources available for staff to use for one-on-one time with the residents and for group activities.  Not all residents in the dementia unit have an activities plan that covers 24 hours. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the resident files reviewed all initial care plans were evaluated by the RN within three weeks of admission. The written evaluations were completed at least six monthly and described progress against the documented goals and needs identified in the care plan. The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 1 July 2016). |
| 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 uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility Individual infection report forms are completed for all infections. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and this is reported at the quality and infection control meetings. The infection control programme is linked with the quality management programme.  Internal infection control audits assist the service in evaluating infection control needs. There is close liaison with the GPs that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were three hospital level residents using a restraint and no residents using an enabler. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Staff education on RMSP/enablers has been provided. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Three restraints were in place for two hospital level residents (two bedrails and one chair brief).  While restraint is in use, monitoring takes place two hourly, as determined on the restraint assessment forms, evidenced in both residents' files.  This is an improvement from the previous audit. |

# 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 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Quality improvement data (eg, complaints, accident/incidents/near-miss events, infections, medication errors, wounds) is collected monthly. Data is collated and analysed through head office. Staff meeting minutes do not reflect evidence of quality results being communicated to staff. | Staff meeting minutes do not reflect communication regarding results of the quality and risk management programmes. | Ensure quality and risk management results are communicated to staff.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | As per policy, corrective actions are to be implemented where audit results are less than 100%. Audit results for 2015 in select areas did not include a documented corrective action plan (eg, call bell testing audit 69%, restraint audit 76%, food services audit 68%, 68%, 67%). Where corrective actions are documented, they are not consistently being signed off to evidence that they have been implemented/resolved. | There is a lack of consistent evidence to verify that corrective actions are documented, implemented and signed off when completed. | Ensure all corrective actions are documented where results exceed thresholds, and are implemented and signed off when completed.  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 | There is an incident reporting procedure and process that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise or prevent further incidents. Individual incident reports are completed for each incident/accident with immediate action noted.  Ten incident forms were reviewed. All forms demonstrated clinical follow up by a registered nurse/care lead and changes to care plans were undertaken when indicated. One of three incident forms sampled where the resident had experienced a suspected head injury, did not have a full regime of neurology observations completed. This area for improvement remains | One of three incidents forms sampled, where the resident had experienced a suspected head injury, did not have a full regime of neurology observations completed. | Ensure that neurology observations are completed for all residents with a suspected head injury.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The GP prescribes all medication to be administered to the resident on admission and then reviews the medications prescribed at least every three months. One respite care resident (rest home) was admitted on warfarin. The warfarin was prescribed by the GP; however, the service had no record of the international normalised ratio (INR) and no record of when the next test was due. | Warfarin had been administered as prescribed to a respite care resident for 22 days, without reference to a recorded INR result or when the next INR test was due. | Warfarin medication to be administered according to current best practice and the prescriber’s instructions.  30 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 | Assessments are completed on admission, when the care plan is reviewed and with a change in health condition. One dementia and two hospital resident files reviewed evidenced that interventions were documented for all identified care needs.  The RN reviews information gathered using assessments and monitoring charts to ensure interventions are documented in the care plans to reflect current care needs. Five RNs have completed InterRAI training and InterRAI assessments were evidenced in the files reviewed.  Not all wound assessments, treatment and evaluations were in place for all current wounds (five skin tears, four lesions, one haematoma and two chronic ulcers). There were two pressure injuries. One pressure injury was documented as grade two and the other pressure injury had no grade documented. Wound care plans were in place for the pressure injuries and adequate pressure management equipment and supplies were sighted. | Interventions were not documented in the care plan for:  i) One dementia resident with challenging behaviours  ii) One rest home resident did not have a short-term care plan documented for an acute infection  iii) Two of twelve wound care plans were documented by a caregiver and were not signed by an RN  iv) Nine of twelve wound care assessments had no description of the wound documented  v) Ten of twelve wound care evaluations did not describe the wound  vi) One of ten wounds was not reviewed in the required timeframe  vii) One of the two pressure-injury wound care plans did not document the grade of the pressure injury, an initial wound assessment or description of the wound with each dressing change. | i) Ensure that interventions are documented for all assessed care needs  ii) Ensure that the organisational policy for care and observations following a fall are followed  iii) Ensure that all wounds have a documented assessment, management plan and evaluation  iv) Ensure that all wounds are reviewed within the required timeframes  v) Ensure that the registered nurse reviews and signs off all care plans and includes the RN designation with the signature.  60 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | In the resident files reviewed, a lifestyle profile was completed on admission in consultation with the resident/family (as appropriate). Activity plans were sighted in the files sampled and these were reviewed six monthly at the same time as the care plans. Activity participation sheets were maintained. The dementia files sampled did not have a 24-hour activity plan documented. | Two of two dementia files reviewed did not have a 24-hour activity plan documented. | Ensure that residents in the dementia unit have an activity plan documented to cover a 24-hour period.  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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| No data to display |

End of the report.