# Ocean View Residential Care

## 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:** Capital Residential Care Limited

**Premises audited:** Ocean View Residential Care

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 25 November 2015 End date: 25 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:** 16

# 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

Ocean View residential care is privately owned and has been under new ownership since March 2015. The service is certified to provide rest home level of care for up to 20 residents. On the day of the audit there were 16 residents.

The owners employ a facility manager, who is a registered nurse with management experience in a community based service. The facility manager has been in the role six months and is supported by a clinical nurse manager with many years aged care experience and who has been in the role ten months. Both managers are supported by a long serving office administrator and experienced care staff.

The owners visit the facility weekly and are supportive of management. Environmental changes include an upgrade of the kitchen, refurbishment of the dining room and new entrance. Renovation of bathrooms has commenced. Residents and relatives commented positively on the standard of care and services provided at Ocean View residential care.

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. The audit process included the review of policies and procedures, the review of residents’ and staff files, observations, and interviews with residents, family, general practitioner, management and staff.

The service has addressed three of eight findings from the certification audit regarding resuscitation status, complaints management and job descriptions.

There continues to be improvements required around internal audit outcomes and communication of resident/relative survey results, attendance at compulsory education, risk assessments, documented interventions and enabler use. This surveillance audit identified improvements required around quality meetings, review of long term care plans, food temperatures and 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. |

The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner that meets the requirements set by the Health and Disability Commissioner.

## 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 medium or high risk and/or unattained and of low risk. |

Ocean View has a quality and risk management system. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards.

There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. Aged care education and online training is available. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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. |

Initial assessments, care plans and evaluations are completed by the clinical nurse manager/registered nurse. InterRAI assessments are in use for all residents. Care plans demonstrate allied health involvement in the care of the resident. Residents and relatives confirmed they were involved in the care planning and review process. The general practitioner reviews residents at least three monthly or more frequently if needed.

A recreational officer provides an activity programme that meets the resident’s individual recreational preferences. Residents are encouraged to maintain community links. There are medication policies and procedures that meet legislation and guidelines. All staff who administer medications have completed an annual medication competency and medication education.

Meals are prepared on site. The menu is varied, appropriate and has been reviewed by the dietitian. Individual dietary needs are catered for. Alternative options are provided.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The service has policies and procedures to appropriately guide staff around consent processes and the use of enablers. The restraint coordinator (enrolled nurse) has a job description. Staff receive training in restraint and managing challenging behaviour. There are no residents with enablers and one resident with restraint.

## Infection prevention and control

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

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical nurse manager) is responsible for the collation and reporting of infections. There are policies and guidelines in place for the definition and surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities 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 | 10 | 0 | 4 | 4 | 0 | 0 |
| **Criteria** | 0 | 32 | 0 | 4 | 5 | 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 | Informed consent processes are discussed with residents and families on admission. Written general consents were sighted in the five resident files reviewed. The two caregivers and the clinical nurse manager confirmed verbal consent is obtained when delivering care. Resuscitation forms in the resident files reviewed had been appropriately signed by the resident and witnessed by the general practitioner. The previous finding regarding written consents has been addressed. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. The facility manager has the overall responsibility for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. A complaints register has been maintained that includes relevant information regarding the complaint. The service has addressed a previous finding relating to maintaining an up-to-date complaints register. Discussion with four residents and relatives confirm they were provided with information on the complaints process.  Three complaints were received in 2015 (year to date) with evidence of appropriate and timely follow up actions taken. Documentation including follow up letters and resolution demonstrates that complaints were well managed. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy and reporting forms that guide staff in their responsibility to notify family of any resident accident/incident that occurs. Incident forms reviewed identified that family were notified following a resident incident. Two relatives interviewed stated they are informed when their family members health status changes. Interpreter policy and contact details of interpreters is available. 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 | Ocean View provides care for up to 20 rest home residents. On the day of audit there were 16 residents. The facility is privately owned by a husband and wife team, who have 11 years of business experience. Fourteen of the residents have aged related contracts and two residents have non-aged related contracts including one on ACC and one on an invalids contract.  Ocean View has a 2015 strategic business plan that includes the home mission statement and philosophy of care. Annual goals relate to residents, staff, quality assurance, risk management and financial goals. The business plan is to be reviewed at a strategic manager/owner meeting scheduled in December 2015. There is on-going review of policies, clinical practice and facility/building improvements. The owners visit the facility weekly to meet with management. Management report the owners have been supportive and committed to improving the environment.  The facility manager is a registered nurse (RN) with a current practising certificate and has worked in community health as a manager. She has been in the role for six months and is supported by a clinical nurse manager who has 20 years aged care experience and been in the role at Ocean View for ten months. The facility manager and clinical nurse manager have maintained over eight hours annually of professional development activities related to managing an aged care service. |
| 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 Moderate | Ocean View has a quality and risk management system. There are policies and procedures 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. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. Two caregivers interviewed confirm they are made aware of any reviewed policies and sign to declare they have read and understood the content. Quality data collated monthly for accidents/incidents are discussed at the bi-monthly staff meetings (minutes sighted). Staff interviewed are aware of infection control and health and safety matters. Internal audits are completed as per schedule. A finding from the previous audit remains around outcomes of internal audits and surveys. Quality meetings have not occurred as scheduled. |
| 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. | FA | The service collects incident/accident data and reports aggregated figures monthly to the staff meeting. Thirteen accident/incident forms for the month of October 2015 were sampled. There has been RN notification and clinical assessment completed within a timely manner. There is documented evidence that the family/whanau had been notified. The facility manager is aware of the provider’s obligation to report events requiring essential notification to authorities. There have been no events to report. |
| 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. The service require police vetting and complete reference checks. Current practising certificates were sighted for the facility manager and clinical nurse manager. Five staff files were reviewed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment. Job descriptions were sighted for the restraint coordinator and infection control coordinator. The previous finding regarding these job descriptions has been addressed.  There is an annual education plan for 2015 which provided at least eight hours of education, however, not all compulsory education has been offered and this remains a finding. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is a facility manager and clinical nurse manager who both work from Monday to Friday and on call. The caregivers, residents and relatives interviewed inform there are sufficient staff on duty at all times. |
| 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 medication policies in place that meet the current medication management guidelines. The facility manager/RN, clinical nurse manager, enrolled nurses and caregivers have completed annual medication competencies and attended medication education. All medications are checked by the RN on delivery and a medication record of checks was sighted. Any discrepancies are fed back to the supplying pharmacy. All medication expiry dates are checked. Standing orders have been signed by the GP however the format does not meet the requirements for standing orders. There was one self-medicating resident on the day of audit. A self-medication competency had not been completed. A shortfall was identified around weekly checks of controlled drugs. Signing administration sheets reviewed against 10 medication charts identified one supplement had not been administered as charted.  Ten medication charts reviewed had photographs and allergy status identified on the charts. Regular and as required medications had been prescribed as per legislative requirements. Not all discontinued medications were dated and signed by the GP.  All 10 medication charts had been reviewed three monthly by the GP. |
| 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. | PA Low | The kitchen flooring, cabinets and benches have recently been replaced. The kitchen has a good workflow and well equipped. All meals and baking is cooked on site. The cooks have completed food safety and hygiene units. There is a food services manual in place to guide staff. The six weekly menu has been reviewed by a dietitian. The clinical nurse manager notifies the cook of residents dietary preferences including likes and dislikes. Residents interviewed stated their dietary needs are accommodated including alternative options.  The temperatures of refrigerators and freezers are recorded weekly. All food was stored appropriately and dated. End cooked temperatures are taken, however, these have not recorded.  Residents and relatives commented positively on the quality and variety of food served. There is an opportunity to provide feedback and meal suggestions through the resident meetings and surveys. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | Appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Not all risk assessments were completed for identified risks. The previous finding around assessments remains.  InterRAI assessments have been completed on admission and six monthly for the four (of five) residents under the aged care contract. The clinical nurse manager has completed interRAI training. All residents under the aged care contract have had an InterRAI assessment completed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident’s condition changes the clinical nurse manager or facility manager (both registered nurses (RN)) initiates a GP visit or nurse specialist consultation. Short term care plans are developed for the management of short term needs and changes in a resident’s health status. Not all interventions had been documented in one of the resident files reviewed around falls prevention and a medical condition. The previous finding around interventions remains. There is evidence of relative notification of health status changes as documented on the family communication form.  Staff have access to sufficient medical and dressing supplies. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence and wound advice is available as needed and nurse initiated referrals could be described.  Wound assessment, wound progress and dressing record forms are available for use. These were in use for one surgical wound. There was documented evidence of GP and district nursing input into the wound management plan. There were no pressure injuries. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service employs a recreational officer for 22 hours a week Monday to Friday. The recreational officer has been at Ocean View for six years and attends regional diversional therapy meetings and workshops. She has a current first aid certificate, Careerforce level 3 and completed dementia unit standards.  The weekly programme includes a variety of activities that meets the recreational preferences and abilities of the residents. Residents were observed participating in activities throughout the audit day. Community links are maintained with visits into the community, inter-home visits, drives and outings. There are regular church visitors, monthly entertainers and pet therapy.  Two monthly resident meetings provide residents with an opportunity to provide feedback on the activity programme.  The activity plans were reviewed at the same time as the clinical care plans in resident files sampled. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans reviewed were updated following the six monthly evaluation and as changes occur in four of five resident files reviewed (link 1.3.6.1 and 1.3.3.3). There were written evaluations that evidenced multidisciplinary input into the review process. Relatives confirmed they are involved in the care plan review. The GP reviews the resident at least a three monthly. Short term care plans (sighted) were used for short term needs. Short term care plans were evaluated and resolved or added to the long term care plan if the problem is on-going. |
| 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 building holds a current warrant of fitness, which expires on 6 June 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 | There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control coordinator (clinical nurse manager) collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates and infection control practice. Hand hygiene audits are completed annually. There have been no outbreaks. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | PA Moderate | The service is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with clinical staff. There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. Restraint minimisation is overseen by a restraint coordinator who is an enrolled nurse with a job description that defines the responsibility around restraint minimisation.  There was one resident identified as requiring a lap belt and bedrails for safety however the resident is unable to consent voluntarily to an enabler. The previous finding around the use of enablers remains. Staff complete restraint and challenging behaviour education. |

# 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 data including accidents/incidents, infections, concerns and complaints are collated monthly and reported to governance and discussed at the bi-monthly staff meetings as evidenced by the meeting minutes sighted. Staff interviewed were aware of infection control and health and safety matters. Internal audits are completed as per schedule. There is an agenda for bi-monthly quality meetings however these have not occurred as scheduled. Outcomes of staff, residents/relatives annual survey are not known to the participants. | i) Not all internal audits have had corrective actions signed off as completed. Audit outcomes are not reflected in meeting minutes. Staff survey results have not been communicated to staff; ii) Resident/relative annual survey results for 2015 have not been feedback to participants; and iii) There is no evidence of bi-monthly quality meetings held for 2015. | i) Ensure outcomes of internal audits and staff surveys are communicated to staff; ii) Ensure outcomes of the annual residents/relatives survey are fed back to participants; and iii) Ensure that quality meetings are held as scheduled.  60 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | There is a completed education plan for 2014 and a current annual education plan for 2015 which provided at least eight hours of education per year. Not all compulsory education has been offered.  The annual education plan for 2014 and 2015 covered some of the compulsory education requirements including code of rights, infection control, restraint, challenging behaviour and medication management. Attendance records had been maintained. The service has recently introduced an online training programme which incorporates 31 training modules. Care staff have access to Careerforce aged care qualifications and a roving assessor. | Complaints management and open disclosure training has not been provided in the last two years. Staff attendance at code of rights was low with seven out of twenty staff attending. | Ensure all staff attend compulsory education/training requirements at least two yearly.  60 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 prescribing of medications met legislative requirements. As required medications included an indication for use. Administration of as required medications included the date and time of administration. The checking out and administration of controlled medications met legislative requirements, however, there was inconsistency around weekly checks. Three of ten medications charts did not meet the GP signing requirements for discontinued medications. The GP has reviewed the standing orders annually which has medications listed for use with maximum doses but no contraindications documented. Nine of ten administration signing sheets corresponded with the medication charts. | i) The controlled medication register does not evidence regular weekly checks as per the medication policy/legislative requirements; ii) The standing orders in use do not document contraindications for the use of the listed medications; iii) The GP had not dated and signed two discontinued medications. A controlled medication had not been discontinued on the medication chart by the GP; and iv) One resident had not received dietary supplements as charted for five consecutive days due to lack of supply. | i) Ensure weekly checks are completed in the register for controlled medications; ii) Ensure the standing orders meet the standing order requirements; iii) Ensure discontinued medications meet the legislative requirements and medications no longer being administered are discontinued; and iv) Ensure there are supplies of dietary supplements available to meet the prescribed requirements.  30 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There was one resident self-administering an inhaler and medication. The medication chart has been reviewed three monthly. The resident stores the medications safely however there has been no self-medication competency completed. | There is no self-medication competency completed for the one self-medicating resident. | Ensure self-medicating competencies are completed and reviewed at least three monthly as per the medication policy  60 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | All foods sighted in the pantry was stored in sealed containers and dated. Fridge and freezer temperatures are recorded weekly and are within the acceptable temperature range. The cook described the procedure for the daily checking of end cooked meat temperatures. | There was no documented evidence of end cooked meat temperatures. | Ensure end cooked meat temperatures are recorded as per food services policy.  60 days |
| Criterion 1.3.3.3  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. | PA Low | The clinical nurse manager is responsible for completing initial assessments, InterRAI assessments, risk assessment tools and developing the care plans. Care plans have been reviewed at least six monthly in four of the five files reviewed. The manager is a registered nurse with a current practicing certificate and available to complete initial assessments on admission as required. | One file of a non-aged resident did not evidence six monthly evaluation of the long term care plan. | Ensure long term care plans are reviewed at least six monthly.  90 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 assessment tools are available and the outcomes of assessments form the basis of the care plan. Risk levels for two residents are reflected in the care plans. | i) One resident identified as having weight loss did not have a review of the mini nutritional assessment. The same resident did not have three monthly pain assessment reviews as documented in the long term care plan; and ii) One resident with identified pain did not have a pain assessment completed on admission. | Ensure risk assessments are completed for residents as applicable.  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 | Residents and family members confirm care delivery and support is consistent with their expectations. Relatives state they are notified of any significant events/heath status changes and are kept informed of progress. There are a number monitoring and observation forms sighted in use including pain monitoring, neurological observations and weight and blood pressure monitoring. Four of five resident files documented appropriate interventions to guide staff in safe delivery of care. | Documented falls prevention interventions/strategies and falls risk level was not documented for one resident identified as a frequent faller. The same resident did not have any documented interventions for seizures. | Ensure documented interventions reflect the resident’s current health status.  30 days |
| Criterion 2.1.1.4  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. | PA Moderate | There are policies around the assessment, defining, monitoring and use of restraints and enablers. There is room for improvement around establishing definition regarding enablers and restraints, assessments and monitoring. An assessment was completed for the use of a lap belt only. | One resident identified as using an enabler had the consent and assessment signed by the legal guardian. The resident is unable to consent voluntarily to the use of a lap belt and bedrails. The assessment was signed by the GP, for the lap belt but no assessment completed for the bedrails. There was no documented monitoring for either the lap belt or bed rails, as per policy. The resident care plan did not identify risks associated with the use of the lap belt and bedrails. | Ensure correct assessments are completed for restraints, which should be assessed and signed by the GP. Ensure there is documented monitoring of restraint usage as per policy. Any enablers should be a voluntary decision made by the resident using them.  30 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.