# T M & D L Beer Holdings Limited - Cardrona

## 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:** T M & D L Beer Holdings Limited

**Premises audited:** Cardrona Rest Home

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

**Dates of audit:** Start date: 18 December 2015 End date: 18 December 2015

**Proposed changes to current services (if any):** Assess the suitability of a double room for rest home level of care.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 33

# 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

Cardrona Rest Home provides rest home and hospital level care for up to 35 residents and on the day of audit there were 33 residents. The service is managed by a general manager and an executive nurse manager. 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 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 policies and procedures, incidents and accidents and pain assessments. Improvements continue to be required in relation to monitoring hot water temperatures.

This surveillance audit identified that improvements are required in relation to performance appraisals, business planning, communicating internal audit results to staff, corrective action plans, equipment, meeting time frames around documentation, and medication management. One room was assessed for suitability as a double occupancy room and is suitable only as a single occupancy room.

## 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. |

Links with family and the community are encouraged and maintained. Families and residents are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## 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. |

Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Adverse event data is collected, collated and analysed. A health and safety programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff that is specific to their role. On-going education and training for staff is maintained.

Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## 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 and care plans are completed by the registered nurses. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. A general practitioner reviews each resident at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

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

A current building warrant of fitness is posted in a visible location. One room is in the process of being upgraded to accommodate two rest home level residents with one resident safely occupying the room.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a restraint policy that includes comprehensive restraint procedures. The service currently has no residents assessed as using a restraint or an enabler. Staff receive training on the principles of restraint minimisation and managing challenging behaviours.

## 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 | 11 | 0 | 4 | 2 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 5 | 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 procedure is provided to residents and relatives at entry to the service. Complaints forms are located at reception. Forms include links to advocacy services.  A record of all complaints received is maintained by the general manager using a complaints register. Documentation including follow up letters and resolution demonstrated that complaints are well-managed. Only one complaint has been lodged in 2015 and was resolved.  Discussions with all five residents (four rest home level and one hospital level) and one family confirmed they were provided with information on complaints and remarked that any concerns or issues they had were addressed promptly. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principles that residents and their families have a right to know what has happened to them and to be fully informed at all times. The two managers and six staff interviewed (one general manager, one executive nurse manager, two caregivers, two registered nurses, one cook, one activities coordinator) understand about open disclosure and providing appropriate information and resource material when required.  One family interviewed (hospital level) confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. There was evidence of open disclosure and notifying family after an adverse event in all fifteen accident/ incident forms reviewed.  An interpreter service is available and accessible if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | Cardrona Rest Home and Hospital provides care for up to 35 residents across rest home and hospital levels of care. On the day of audit there were twenty-three rest home level and seven hospital level residents. Twelve residents’ rooms are dual purpose. One hospital level resident was on the ‘young person with disability’ (YPD) contract and one rest home level resident was on the ‘long term chronic conditions’ (LTCC) contract. Two residents on respite at rest home level were being admitted on the day of the audit.  A mission, philosophy and nursing objectives were established in 2014. Business planning specific to the facility/organisation and evidence of business goals with regular reviews were missing.  The general manager was employed in February 2015. She is responsible for all non-clinical related activities for two aged care facilities with the same ownership. Previous experience was held with the Ministry of Primary Industries. She is supported by a full time executive nursing manager/registered nurse who works at this site and another site owned by the same owners in another town and has worked in the aged care sector for 18 years, holds post graduate qualifications in advanced nursing and has been at this facility for approximately five years.  The general manager has maintained at least eight hours of professional development activities related to managing an aged care facility over the past ten months. |
| 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 quality and risk management system is established. Policies and procedures are developed and maintained by an external consultant who ensures that they are reviewed a minimum of two yearly, align with current good practice and meet legislative requirements. Policies and procedures are being implemented, which is an improvement from the previous audit, although a gap remains around monitoring hot water temperatures (link 1.4.2.1). Processes around interRAI are included in service delivery policies.  Quality management systems include completing internal audits, incident and accident reporting, health and safety reporting, infection control data collection and complaints management with staff kept informed with the exception of internal audit results, which are not regularly communicated to staff. Documented evidence of corrective action plans and the implementation of these plans were also missing.  A risk management plan is in place. Actual and potential risks are documented in the hazard register which identifies a risk rating and shows actions to eliminate or minimise the risk. Staff interviewed understood the process around reporting and managing newly found hazards.  There were no residents with a pressure injury. Falls management strategies include sensor mats, intentional rounding and the development of specific falls management plans to meet the needs of each resident who is at risk of falling. |
| 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 | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise future events and debriefing. Individual reports are completed for each incident/accident with immediate action noted including any follow up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Adverse events identified in the residents’ progress notes had an accompanying accident incident report completed.  Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Actions were identified on the accident/incident report when the accident/incident was documented as ‘preventable’. These are improvements from the previous audit.  The general manager and executive nurse manager are aware of their responsibility to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed included evidence of the recruitment process, signed employment contracts, police vetting, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service. A copy current practising certificates are stored on file.  There is an annual education schedule that is being implemented and meets requirements. Three registered nurses (RNs) have completed their interRAI training. Missing was evidence of annual performance appraisals for the RNs. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The executive nurse manager and/or general manager are on site five days a week. A minimum of one RN and two caregivers are on site 24 hours a day, seven days a week.  Staffing is flexible to meet the acuity and needs of the residents. Interviews with residents and families confirmed staffing overall was satisfactory. |
| 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 | Medications are administered by registered nurses (RNs) only. The RNs have completed annual medication competencies and medication education. One RN interviewed was able to describe her role in regard to medicine administration. The RN was observed administering medications safely. There were no self-medicating residents at the time of the audit. Medications were securely and appropriately stored. The service has standing orders but these are only to be administered by the executive nurse manager who has been assessed as competent to do this by the GP.  Medication profiles reviewed did not consistently evidence that allergies were documented due to transfer to digital charts. Old charts remained accessible with required information present. Ten profiles evidenced that the GP had reviewed the residents’ medications three monthly. ‘As required’ medication did not consistently evidence indications for use that were specific to the individual resident. |
| 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 | There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who need special diets and the cook works closely with the RN and care staff. The kitchen staff have completed food safety training. The cook stated at interview that the menus are reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were happy with the quality and variety of food served. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly (in four of five files (link 1.3.3.3)) or when there was a change to a resident’s health condition in files sampled. Care plans reviewed were developed on the basis of these assessments for files sampled. Pain and continence assessments (where applicable) were in place in the files reviewed. The previous audit findings have now been addressed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Dressing supplies are available and a treatment room/cupboard is stocked for use. Continence products are available and residents’ files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.  Wound assessments and wound management plans were in place in 16 residents’ files. The wound management plans include the timeframe for review of the wounds. All wounds had been reviewed in the stated timeframe. One of the registered nurses interviewed described the referral process should they require assistance from a wound specialist.  Registered nurses (RNs) and caregivers follow the care plan and the RN’s report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral. If external medical advice is required this will be actioned by the GP. Specialist continence advice is available as needed and this could be described.  Short term care plans were in use for changes in residents’ health status.  Care plan interventions including intentional rounding and food and fluid charts demonstrated interventions to meet residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service has an activities coordinator who works 20 hours a week. The service has a five day week programme and activities were observed occurring. On-on-one time occurs on an individual basis for those residents who choose not to participate in activities. Care staff are also involved in activities. There is a variety of activities provided. A van is available for resident’s outings. Residents enjoy weekly outings and shopping trips. Community links are maintained with groups and individual visitors. There are church services three times a month. There is a residents meeting held monthly. An activity plan is developed for each individual resident based on assessed needs as part of the care plan. Monthly progress notes are recorded and attendance records are kept. The activity plan is reviewed six monthly along with the residents nursing care plan. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans were evaluated by the registered nurse within three weeks of admission in files sampled. In three of four files reviewed (one resident had not been at the service for six months) the long term care plan was evaluated at least six monthly or earlier if there was a change in health status in files sampled (link 1.3.3.3). There was at least a three monthly review by the GP in these files. All changes in health status were documented and followed up. Care plan reviews are signed by the RN in files sampled. Short term care plans were evaluated and resolved or added to the long term care plan if the problem is on-going in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | The service displays a current building warrant of fitness.  There was no evidence to verify monitoring hot water temperatures. The previous area for improvement remains. Medical equipment and electrical appliances have been tested and tagged. Calibration of equipment occurs annually. The platform scale was broken on the day of the audit. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The registered nurse is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly resident infection data sheet and then analysed and evaluated and reported to staff meetings. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in the Standard (NZS 8134.0). The policy includes restraint procedures. Interviews with the restraint coordinator/RN and staff confirmed their understanding of restraint minimisation.  The service had no residents using enablers or restraints. |

# 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 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | The documented mission, philosophy, and nursing objectives were developed as a generic tool by an external consultant and were last reviewed on 17 December 2014. The general manager remarked that she is aware of this gap and has plans in place to develop a business plan with specific and measurable goals. | A business plan with associated business goals, specific to the facility/organisation has not been established. | Ensure that the business plan reflects the uniqueness of the facility and has associated business goals that are specific, measurable and are regularly reviewed.  90 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 | Adverse event data (e.g., falls, skin tears, staff accidents, infections) links to the quality and risk management programme with data collated, analysed and results communicated to staff. This was evidenced both in the monthly staff meeting minutes and via bar graphs posted on the wall of the staff room. The analyses of data include targeted improvement notes and recognising staff for improvements. Missing was evidence of staff being kept informed about results of internal audits. | Whilst staff are provided with quality results relating to adverse event data, internal audit results are not regularly communicated to staff. | Ensure staff are regularly kept informed regarding the results of completed internal audits.  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 | Areas that are identified as requiring improvements were being addressed, as evidenced in interviews with the general manager and executive nursing manager although corrective action plans and evidence of their implementation were not being documented. | Documented evidence of corrective action plans and the implementation of these plans were missing. | Ensure corrective actions are documented with evidence of their implementation.  90 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The annual education schedule meets contractual requirements. In addition, opportunistic education is provided. Discussions with staff and management confirmed that an education and training programme in relevant aspects of care and support is in place with support provided by the Waikato District Health Board. Three of seven RNs, including the executive nurse manager have completed their interRAI training. Missing was evidence of annual performance appraisals for the RNs. All other staff had an annual performance appraisal completed. | Annual performance appraisals are up-to-date for all staff with the exception of the RNs. | Ensure annual performance appraisals are completed for the RNs.  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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. Missing was consistent evidence of allergies documented; and ‘as required’ medications for use, specific to the individual resident. The service had changed to digital charts the previous day. | (i) In six of ten charts reviewed ‘as required’ medication indications for use were not specific to the individual resident and (ii) In four of ten charts reviewed allergies were not documented. | (i) Ensure that indications for use for as required medication are specific to the resident and (ii) Ensure that all medications charts have allergies or no known allergies documented.  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 registered nurse completes initial assessments and an initial care plan on admission. Four of five long term care plans were completed within 21 days of admission. Four of five residents’ files had risk assessments completed six monthly or as required. Three of four files reviewed (one had not been at the service for six months) were reviewed and evaluated against stated goals six monthly or as required. | (i) In one of five files reviewed (a rest home level resident) the interRAI assessments were not reviewed within the six month time frame required, (ii) In one of five files reviewed (a hospital level resident) the long term care plan was not commenced within 21 days of admission and (iii) One of four care plan evaluations (a rest home level resident) had not been completed at least six monthly. | Ensure that assessments, care plans and evaluations are completed within the required timeframes.  90 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Moderate | A current building warrant of fitness is posted in a visible location (expiry date 9 December 2016).  Electrical equipment has been tested and tagged in 2015. The platform scale was broken on the day of the audit. Documented evidence of monitoring hot water taps was missing and maintenance staff were not available during the audit to be interviewed. This previous area for improvement remains.  The service has applied to HealthCERT to approve the addition of one room for two rest home level residents. This room has been converted and is suitable for a single resident. The room has ample space, a call bell within the resident’s reach, and a sink for hand washing. This room is not yet ready to accommodate two rest home level residents. | (i) Five residents were unable to be weighed due to a broken platform scale.  (ii) The auditor was unable to evidence monitoring hot water temperatures of residents’ water taps.  (iii) The room that was assessed for two rest home level residents is missing one call bell, and a privacy curtain. The sink in the room does not allow for segregation of personal items between two residents. | (i) Ensure the platform scale is repaired.  (ii) Hot water temperature monitoring is required.  (iii) The proposed double room for two rest home level residents requires an additional call bell, privacy curtain and must meet infection control standards if a sink is shared between two residents.  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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End of the report.