

# CHT Healthcare Trust - St Margaret's Hospital and Rest Home

---

## 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](#).

The specifics of this audit included:

<b>Legal entity:</b>	CHT Healthcare Trust
<b>Premises audited:</b>	St Margaret's Hospital and Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
<b>Dates of audit:</b>	Start date: 11 November 2015    End date: 12 November 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	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
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

CHT St Margaret's is owned and operated by the CHT Healthcare Trust. The service provides care for up to 88 residents requiring rest home, hospital and dementia level care. On the day of the audit there were 84 residents. The service is managed by a nurse manager who is sufficiently experienced. The residents and relatives interviewed 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 a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, families, management and staff.

The service has addressed eight of twelve shortfalls from the previous certification audit around advance directives; the quality and risk management programme; the pre-employment screening process; long term care plans and cultural assessments; family and resident involvement in care planning; aspects of medication documentation; first aid training; and restraint evaluations. Four improvements continue to be required in relation to incident follow up by a registered nurse, dementia training for staff, wound evaluations and restraint assessments.

This surveillance audit identified that improvements are required around the orientation programme for new staff, monitoring restraint use, and activity care plans.

## Consumer rights

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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

Residents and family report communication with management and staff is open and transparent. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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.
---	--	--

The unit manager is a registered nurse. She is supported by an area manager, a clinical coordinator, registered nurses and other care and support staff. The quality and risk management programme includes a service philosophy, goals and a quality planner. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings provide a forum to discuss quality and risk management processes. Residents meetings are held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. Appropriate employment processes are

adhered to and employees have an annual staff appraisal completed. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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 low risk.
--	--	---

Assessments (including InterRAI), care plans and evaluations are completed by the registered nurses. Care plans are individualised and risk assessment tools and monitoring forms are available. Care plans are evaluated six monthly.

The team of four activity coordinators provide a seven day activities programme for the rest home/hospital and dementia care residents that is varied, interesting and involves community visitors and outings. The programme meets the recreational, spiritual and cultural preferences of the consumer groups.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration complete annual competencies and education. The general practitioner (GP) reviews the medication chart three monthly.

An external contractor prepares meals on site and the menu has been approved by a dietitian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

## Safe and appropriate environment

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

A current building warrant of fitness is posted in a visible location. There is a first aid trained staff member on duty at all times.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Some standards applicable to this service partially attained and of low risk.
---	--	---

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 six residents with restraint and no residents with an enabler. The restraint coordinator is the clinical coordinator. She is responsible for ensuring restraint management processes are followed.

## Infection prevention and control

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



Standards applicable to this service fully attained.

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.

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)
<b>Standards</b>	0	16	0	5	1	0	0
<b>Criteria</b>	0	39	0	6	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>In the resident files sampled the CPR forms had all been completed and signed correctly, there was evidence that the GP had discussed resuscitation with the family, and the CPR forms had correctly noted competency and had been signed correctly, The previous audit findings have been addressed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Care staff interviewed (five healthcare assistants (HCAs) and three registered nurses) were able to describe the process around reporting complaints.</p> <p>There is a complaints register. Six complaints lodged for 2015 (year to date) were reviewed. All six complaints have undergone an investigation, and met expected time lines. Corrective actions are developed when required. The complaints process is linked to the quality and risk management programme.</p>

		Discussions with all six residents (three rest home level and two hospital level and one residential disability) and families confirmed that issues are addressed and that they feel comfortable bringing up any concerns.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	PA Low	Residents interviewed stated they were welcomed on entry and were 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.  Incident/accident forms include a section to record family notification. This may also be documented in the resident's progress notes. Documentation does not evidence that family are always kept informed following an adverse event. All five families interviewed (one rest home level, two hospital level and two dementia level) confirmed they were notified of any changes in their family member's health status.  An interpreter policy and contact details of interpreters are available. Interpreter services are used where indicated.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	St Margaret's Hospital is owned and operated by the CHT Healthcare Trust. The service provides rest home, dementia, residential disability and hospital level care for up to 88 residents. All beds in the rest home/hospital areas are dual purpose. Four residents were on the Young Persons with Disability (YPD) contract under residential disability certification and the remaining residents were on the Aged-Related Care Contract.  On the day of the audit there were 84 residents (8 rest home level, 19 dementia level and 57 hospital level). The unit manager is a registered nurse (RN) who has been in this role for fourteen months. She has 20 years of management experience in both the disability and private sectors. She is supported by a clinical coordinator/RN who has been in her role at this facility for 12 months. The unit manager reports to the CHT area manager regularly on a variety of operational issues.  CHT has an overall business/strategic plan, philosophy of care and mission statement. St Margaret's has an annual facility-specific business plan which links to the organisation's strategic plan and is reviewed monthly with the CEO.  The unit manager has completed a minimum of eight hours of professional development relating to the management of an aged care service in the past 12 months.

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A 2015 quality and risk management programme is in place. Interviews with the area manager, unit manager, clinical coordinator and care staff reflect their understanding of the quality and risk management systems that have been put into place.</p> <p>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. Policies are regularly reviewed. Policies and procedures are being updated to include reference to InterRAI for an aged care service. New policies or changes to policy are communicated to staff, evidenced in meeting minutes.</p> <p>Data collected (e.g., falls, medication errors, wounds, skin tears, complaints, infections) are collated and analysed with results communicated to staff in the quarterly quality/health and safety staff meetings and the monthly registered nursing meetings, evidenced in the meeting minutes. These are improvements from the previous audit. Results are also posted in the staff room for staff to view.</p> <p>Internal audits are completed six-monthly by the area manager. Areas of non-compliance include the initiation of a corrective action plan with sign-off by the area manager when implemented.</p> <p>A health and safety programme is in place. CHT has achieved a tertiary rating for the ACC Work Safety Management Practice (WSMP).</p> <p>Falls prevention strategies include a comprehensive investigation of residents' falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. The facility has purchased beds that can be lowered to low levels, and sensor mats. Hip protectors are used to prevent injuries from falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>There is an accidents and incidents reporting policy. Adverse events are linked to the quality and risk management programme. There was evidence to support actions are undertaken to minimise the number of incidents. Clinical follow up of residents, conducted by a registered nurse, was missing in a selection of accident/incident forms and remains an area for improvement. Care plans sampled were updated in relation to incidents.</p> <p>Discussions with the unit manager and area manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>PA Low</p>	<p>There are human resource management policies in place which includes the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>and veracity including reference checks, evidenced in all six staff files reviewed. This is an improvement from the previous audit.</p> <p>Copies of practising certificates are kept on file. The service has implemented a general orientation programme that provides new staff with relevant information for safe work practice. Missing was evidence of completed induction checklists in two of the six files. Also missing were job specific induction plans. Annual staff appraisals were evident in all staff files reviewed.</p> <p>The in-service education programme for 2014 has been completed and a plan for 2015 is being implemented. Weekly in-services are provided by a range of in-house and external speakers including but not limited to nurse specialists, Aged Concern and the Health and Disability Advocacy Service. Not all HCAs who work in the dementia unit have completed the required Aged Care Education (ACE) dementia qualification. This previous area for improvement remains.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>CHT policy includes staff rationale and skill mix. Sufficient staff are rostered 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 resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Twelve medication charts were reviewed (two rest home, six hospital, four dementia). There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges.</p> <p>All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly. The previous audit findings relating to medication prescribing have been met.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The meals at CHT St Margaret's are all prepared on site by an external contractor. There is a four weekly seasonal menu that is designed and reviewed by a registered dietitian. The cook receives resident dietary information from the RN's and is notified of any changes to dietary requirements (vegetarian, moulid 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 those residents with dislikes or religious preferences. Additional nutritious snacks are available over the 24 hour period for the dementia residents.</p> <p>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 all completed food safety and hygiene courses.</p> <p>The residents interviewed are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys.</p> <p>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 all completed food safety and hygiene courses.</p> <p>The residents interviewed are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the resident meetings and through resident surveys.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>In the files sampled all residents had a completed care plan which was resident centred and demonstrated service integration and input from allied health. There was evidence of family and resident involvement in the development of the care plan. Cultural needs were documented in all files reviewed. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Care plans were amended to reflect acute changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of input from a range of specialist care professionals.</p> <p>The previous audit findings around care planning have been addressed.</p>
<p>Standard 1.3.6: Service</p>	<p>PA Low</p>	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>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.</p> <p>Two hospital residents did not have interventions documented for all identified care needs. This is a previously identified issue that continues to require improvement (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 1. 3. 7).</p> <p>Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP dietician and specialist involvement in wounds/pressure areas. Improvements are required around reviewing of wounds within the required time frames.</p> <p>Contenance products are available and resident 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.</p> <p>The clinical files sampled evidenced involvement of referral to allied health and specialist serves as required including speech language therapist, physiotherapist, dietician, skin specialist, podiatrist, and wound care specialist.</p> <p>In the files reviewed there was evidence of pain assessments being completed where pain had been identified. The previous audit finding relating to pain assessments has been addressed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>PA Low</p>	<p>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.</p> <p>Care staff were observed at various times through the day diverting residents from behaviours in the dementia unit, and participating in one on one activities with residents in the rest home and hospital areas. The individual activities observed were appropriate for older people. There are resources available for care staff to use for one on one time with the resident. Relatives and residents stated they were satisfied with the activities provided. Not all residents in the dementia unit had 24 hours activity plan documented.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>In the residents' files reviewed all initial care plans were documented and evaluated by the RN within three weeks of admission. Long term care plans had been reviewed at least six monthly or earlier for any health changes. The GP reviews the residents at least three monthly or earlier if required. Evidence</p>

comprehensive and timely manner.		of three monthly GP reviews were seen in all residents' files sampled. On-going nursing evaluations occur daily/as indicated and are documented within 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 date 16 September 2016).
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. This is an improvement from the previous 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	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. This is kept as part of the resident files. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at the quality, and infection control meetings. The infection control programme is linked with the quality management programme.  There is close liaison with the GP's 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	FA	The service has documented systems in place to ensure the use of restraint is actively minimized. There were six residents with restraint (five hospital level and one dementia level) and no residents using an enabler. Hospital level residents are not allowed in the secure dementia unit, confirmed in policy and in

<p>use of restraint is actively minimised.</p>		<p>interviews with the unit manager and care staff. This is an improvement from the previous audit.</p> <p>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 definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP /enablers has been provided. Restraint is discussed as part of staff meetings. The clinical coordinator is the designated restraint coordinator.</p>
<p>Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Restraint assessments are undertaken by the restraint coordinator/RN in partnership with the resident and their family/whanau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Two residents' files were reviewed where restraint was in use. A restraint assessment tool was completed for each resident requiring an approved restraint. Evidence of consultation and consent were provided by the family/EPOA. Completed assessments considered those listed in in 2.2.2.1 (a) - (h). This is an improvement from the previous audit.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>PA Low</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints include bed rails and lap belts. The restraint coordinator is responsible for ensuring all restraint documentation is completed.</p> <p>Residents using restraint have restraint use identified in their care plan. This is an improvement from the previous audit. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Completed monitoring forms do not always correlate with the frequency of monitoring determined by the restraint assessment. This previous area for improvement remains.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations occur at least six-monthly as part of the on-going reassessment for the residents on the restraint register, and as part of the care plan review. Families are included as part of this review. A review of two files of residents using restraints identified that evaluations are up-to-date. This is an improvement from the previous audit.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	Families report that they are kept informed although this was unable to be evidenced in a selection of the incident/accident forms and associated progress notes reviewed.	Two of ten accident/incident forms did not reflect families/EPOA being notified following an adverse event.	<p>Ensure families/EPOA are kept informed following an adverse event unless they have indicated otherwise.</p> <p>60 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service</p>	PA Moderate	Adverse events are documented on an accident/incident form. All ten accident/incident forms selected for review reflected immediate action was	Two of ten accident/incident forms did not reflect an investigation by the	Ensure all clinical accident/incidents

shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.		undertaken by a registered nurse, but evidence of an investigation was missing in two of the ten forms.	registered nurse.	include a follow-up investigation by a registered nurse.  60 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	New staff are provided with an induction programme that covers essential components. Missing is evidence of job-specific training. Evidence of completed induction checklists were missing in two of six staff files reviewed.	Two of six staff files were missing evidence of a completed general induction checklist. A job specific induction programme has not been implemented.	Ensure that all staff files can evidence completion of an induction programme. Job specific induction programmes are required.  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 Low	An education and training plan (2015) is in place for all staff with evidence of weekly in-services. Compulsory education and training is implemented meeting contractual requirements. HCAs are strongly encouraged to complete the Aged Care Education (ACE) training programme.	Ten HCAs are regularly rostered to work in the dementia unit. Seven of the ten have completed their ACE dementia qualifications. Two have been employed for less than one year and are enrolled in the ACE dementia training programme. Missing is evidence of the required dementia qualification for one HCA staff who works in the dementia unit one day a week and for HCA staff who	As per contractual requirements, ensure all HCA staff working in the dementia unit who have been employed for over one year have completed their ACE

			fill in for staff absences.	dementia qualification.  90 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	<p>Assessments are completed on admission, when the care plan is reviewed and with a change in health condition. Two hospital residents did not have interventions documented for all identified care needs. Interventions were not specific about the care required in two dementia files reviewed.</p> <p>The RN reviews information gathered through the use of assessments and monitoring charts to ensure interventions are documented in the care plans to reflect current care needs. Four RN's have completed interRAI training and interRAI assessments were evidenced in the files reviewed.</p> <p>Wound assessments, treatment and evaluations were in place for all current wounds (one skin tear, one ulcer, one laceration, one surgical). Not all wounds had a documented review of the wound in the required time frames. There were no pressure injuries on day of audit. Adequate pressure management equipment and supplies were sighted.</p>	<p>i) Interventions were not documented in the care plan for one hospital resident with weight loss and one hospital resident with an upper respiratory tract infection. Interventions were not detailed about the actions or monitoring required for two dementia residents in relation to monitoring for depression, infection, delirium and their and whereabouts.</p> <p>ii) Four of four wounds care files reviewed had not documented a review of the wound in the required time frames.</p>	<p>i) Ensure interventions are documented for all assessed care needs.</p> <p>ii) Ensure that all wounds have a documented review of the wound within the required time frames.</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to</p>	PA Low	In the resident files reviewed a lifestyle profile was completed on admission in consultation with the resident/family (as	Two of two dementia files sampled did not have an activities plan documented	Ensure that residents in the dementia

<p>develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>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 also maintained. The service also receive 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.</p> <p>The dementia files sampled did not have a 24 hour activity plan documented.</p>	<p>that covered the 24 hour period.</p>	<p>unit have a 24 hour activities plan.</p> <p>90 days</p>
<p>Criterion 2.2.3.2</p> <p>Approved restraint is only applied as a last resort, with the least amount of force, after alternative interventions have been considered or attempted and determined inadequate. The decision to approve restraint for a consumer should be made:</p> <p>(a) Only as a last resort to maintain the safety of consumers, service providers or others;</p> <p>(b) Following appropriate planning and preparation;</p> <p>(c) By the most appropriate health professional;</p> <p>(d) When the environment is appropriate and safe for successful initiation;</p> <p>(e) When adequate resources are assembled to ensure safe initiation.</p>	<p>PA Low</p>	<p>Residents using restraint have links in their care plan to alert staff. The residents' care plans include interventions to guide staff in restraint use and managing the risks of restraint. Frequency of monitoring is determined by the restraint assessment and is documented on the restraint monitoring forms. Monitoring times frames when restraint is on and off for lap belts did not always match the one hourly or two hourly times frames determined.</p>	<p>Two residents using laps belts as a restraint did not have monitoring forms that matched the frequency of time frames for monitoring the use of restraint.</p>	<p>Ensure staff monitor residents using restraint at the frequency determined by the restraint assessment.</p> <p>60 days</p>

--	--	--	--	--

## Specific results for criterion where a continuous improvement has been recorded

---

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display
--------------------

End of the report.