# Presbyterian Support Central - Kandahar

## 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:** Presbyterian Support Central

**Premises audited:** Kandahar Court||Kandahar Home

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

**Dates of audit:** Start date: 18 February 2016 End date: 19 February 2016

**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:** 64

# 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 |
|  | 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

Kandahar is part of the Presbyterian Support Central group and provides rest home, hospital and dementia care for up to 88 residents. On the day of the audit there were 64 residents. The service is managed by a facility manager (non- clinical) and two care managers. 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 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 four of seven shortfalls from the previous certification audit relating to policy reviews for medication and restraint and restraint documentation and practice. Improvements continue to be required in relation to conducting neurological observations, resident assessments and medication management practices.

This surveillance audit identified that improvements are required in relation to frequency of meetings, care interventions, activities plans, evaluations and medication prescribing.

## 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. |  | Standards applicable to this service fully attained. |

The service ensures effective communication with all stakeholders including residents and families. Complaints processes are implemented and complaints and concerns are managed and documented. .

## 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. |

PSC Kandahar continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

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

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews resident’s needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals.

The recreation team provide an activities programme for the residents that is varied, interesting and involves the family/whānau and community.

Medication policies comply with legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete education and medication competencies.

All meals are prepared on site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents, family/whānau interviewed responded favourably to the food that was 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 building 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. |  | Standards applicable to this service fully attained. |

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents requiring enablers and five residents assessed as requiring the use of 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 surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 12 | 0 | 3 | 4 | 0 | 0 |
| **Criteria** | 0 | 33 | 0 | 5 | 3 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

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

|  |  |  |
| --- | --- | --- |
| **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 | There is a complaints policy to guide practice and this is communicated to resident/family. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaints register that records activity. Complaints are discussed at the monthly senior management team meeting and the monthly staff meetings. Complaints forms are visible around the facility on noticeboards. There were five documented complaints in 2015 and 2016 year to date. Follow up letters, investigation and outcomes were documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service has an open disclosure policy. Discussions with five residents (two from the hospital and three from the rest home) and three family members (one hospital, one rest home and one dementia) confirmed they were given time and explanation about services and procedures on admission. Resident meetings occur quarterly and the facility manager and care managers have an open door policy. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve accident/incident forms sampled from January and February 2016 identify that family were notified following a resident incident. Interview with five health care assistants (HCA), four registered nurses (RN) and two care managers confirmed that family members are kept informed.  The residents and relatives interviewed confirmed family have been informed when the resident health status changes. The service has an interpreter policy to guide staff in accessing interpreter services. Dementia residents and their families were also given information regarding PSC policy on the management of challenging behaviour. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Kandahar Homes are part of the Presbyterian Support Central organisation (PSC). The service provides rest home, hospital and dementia care levels of care for up to 88 residents between Kandahar Home (33 rest home beds and 30 hospital beds) and Kandahar Court (25 dementia care beds). On the day of the audit there were 64 residents. There were 23 rest home level residents, 21 hospital level resident and 20 dementia care residents. There was no respite or younger person’s residents or residents on the medical component. All residents were on the ARC contract. Kandahar has a 2015-2016 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden alternative and health and safety. Progress towards goals (and objectives) is reported through the manager reports taken to the monthly senior management team meeting.  The facility manager was away on the day of the audit. The facility manager (non-clinical) has been in the role for three years and is responsible for the daily operations of both Kandahar facilities, the support staff and recruitment. He is supported by a quality co-ordinator (RN) who has been in the role for four years. There is a care manager (RN) at each site and both are experienced in aged care. The facility manager is supported by a regional manager (non-clinical) who visits the site weekly. |
| 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 | PSC has an overall Quality Monitoring Programme (QMP) and participates in an external quarterly benchmarking programme. The monthly and annual reviews of this programme reflect the service’s ongoing progress around quality improvement. There is a meeting schedule including monthly senior management team meetings that includes discussion about accident and incident trends, internal audit outcomes, infection trends and complaints. Meeting minutes and reports are provided to the quality improvement (full facility) meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness. Registered nurse meetings and Eden Alternative meetings have not been held as planned. Health and safety, infection control and restraint meetings occur three monthly. Resident/family meetings are held for Kandahar Home three monthly and for families (of both homes) six monthly.  Infections and accidents/incidents are also being documented on an electronic database. The service has a health and safety management system and this includes a health and safety rep that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee meeting. Health & Safety meetings include identification of hazards and accident/incident reporting and trends. Emergency plans ensure appropriate response in an emergency.  The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. A document control system is in place. A policy has been developed/updated to manage InterRAI requirements. The policy for the use of enablers aligns with the restraint minimisation and safe practice for the 2008 Health and Disability Sector Standards. The medication policy around timeframes for staff for medication competencies aligns with the Ministry of Health medication guidelines. The previous audit finding related to the enabler and medication policies has been addressed.  Annual resident and relative satisfaction surveys have been completed as per company schedule which included an analysis and the development of corrective action plans. There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Quality and senior team meeting minutes include an analysis of incident and accident data and corrective actions. The previous audit shortfall remains a finding.  Discussions with the service confirm that there is an awareness of the requirement 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. | FA | There are human resources management policies in place, which includes recruitment. Staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files were reviewed (one care manager, two RNs, one cook, one recreational therapist, one cleaner, and two HCA’s). All files contained a current position description and employment agreements. Annual appraisals have been completed and are up to date. The service has an orientation programme available that provides new staff with relevant information for safe work practice. Staff report that a buddied orientation period is undertaken by all new staff.  The in-service education programme for 2016 is being implemented. The majority of HCA’s have completed an aged care education programme. Staff attend annual compulsory study days which includes training around the Eden alternative programme. The care managers and RN’s are able to attend external training. Eight hours of staff development or in-service education has been provided annually. All individual records and attendance numbers are maintained. There are 20 heath care assistants on the roster in the dementia unit and all have completed their Limited Credit Dementia programme. |
| 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. The facility manager and care managers work full time. Registered nurses cover each 24 hour period in the hospital area. Agency staff are used to provide cover for sickness if necessary. The HCA numbers per area are adequate. In the dementia unit there is an RN rostered on 7 days a week, 8.00am to 4.30pm Monday to Friday and in the weekends 7.00am to 3.30pm. Interviews with HCA’s, residents and family members identify that staffing is adequate to meet the needs of residents. Staff levels and skill mix are meeting contract and industry norm requirements. Staffing levels are benchmarked against other PSC facilities. |
| 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 | Ten medication charts were reviewed (four rest home, four hospital, and two dementia). There are policies and procedures in place for safe medicine management. All clinical staff who administers 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 was one resident self-medicating on the day of audit whose management and practice aligns with organisational policy.  The medication fridge temperatures are recorded regularly and these are within acceptable ranges.  Not all medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed the medication at least three monthly. Separate signing sheets for weekly and monthly medication were not being used. The previous audit findings relating to medication prescribing remains. |
| 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 | All meals at Kandahar are prepared and cooked on site. There is a four weekly seasonal menu which had been reviewed by a dietitian. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. Nutritious snacks are available 24 hours a day for residents in the dementia unit.  Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.  Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures are recorded daily of meals before serving. All food services staff have completed training in food safety and hygiene and chemical safety. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | Files sampled indicated that personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments were not all completed within 21 days of admission or following a change in health condition (Link 1.3.3). There was evidence that assessments were reviewed at least six monthly. The information gathered from nursing assessments was not always used to inform care planning. The previous audit finding related to assessments meeting contractual and resident requirements remains. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.  In the residents’ files reviewed not all short term care plans were commenced with a change in heath condition. Short term care plans sampled were linked to the long term care plan.  Continence 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.  Not all residents had interventions documented in their care plan to meet their assessed care needs. Not all interventions were documented in the care plans and accident/incident forms were followed (link # 1.2.4.3). Not all interventions being implemented were documented. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | The recreational team provide individual and group activities in the rest home, hospital and dementia care units seven days per week. The recreation programme is supported by a team of volunteers. The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. There are regular outings/drives, inter-home visits for all residents (as appropriate) and involvement in community events. One on one activities occur for residents who are unable or choose not to be involved in activities.  An activity profile is completed on admission in consultation with the resident/family (as appropriate). Not all files reviewed had a documented recreational plan and not all recreational plans had been reviewed six monthly at the same time as the care plans were reviewed. There were 24 hour activity plans documented for residents in the dementia unit. Activity participation was noted in the progress notes.  The service receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families.  Relatives and residents stated they were satisfied with the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | 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, however, not all evaluations had reviewed all nursing assessment information. The GP and nurse practitioner reviews the residents at least three monthly or earlier if required. Evidence of three monthly GP reviews were not 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 | The building holds a current building warrant of fitness, which expires 1 July 2016. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.  There have been no outbreaks since the previous audit. Systems are 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. | FA | There is a restraint minimisation and safe practice policy applicable to the service that complies with the Restraint Minimisation and Safe Practice Guideline 2008. The organisational policy for restraint minimisation and enabler use ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register.  On the day of audit there were five hospital residents using restraints (two lap belts and three bedrails) and no residents using enablers. Documentation was reviewed for five residents using a restraint and evidences assessment, authorisation, consent, planning, monitoring and review of the devices aligns with the policy guidelines. The previous audit finding related to restraint minimisation has been met. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require restraint or enabler interventions.  These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the five restraint files sampled.  The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process.  In the files reviewed, assessments and consents were fully completed. The risks associated with the use of the restraint were documented and care interventions documented to manage the risks. The previous audit finding has been met. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met.  There is an assessment form/process that is completed for all restraints and enablers. The service has a restraint and enablers register which is updated each month. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed. Appropriate documentation related to safe restraint practice has been completed. The previous finding related to restraint monitoring has been addressed. |

# 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)** |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | There is a meeting schedule including monthly senior management team, monthly quality improvement (full facility) meetings. Registered nurse and Eden alternative meetings are scheduled to be held monthly but these have not routinely occurred. Health and safety, infection control and restraint meetings occur three monthly. Resident/family meetings are held monthly. | Eden and registered nurses meetings are scheduled to be monthly. There is no evidence of Eden meetings being held for July to December 2015. Eden meetings were cancelled for January, February and May 2015. There was no evidence of a registered nurses meeting for December 2015. | Ensure that all scheduled meetings are held.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | A monthly incident/accident report is completed which includes an analysis of data collected. Accident/incident forms were sampled from January and February 2016. One of six residents who suffered an unwitnessed fall had neurological observations and assessment conducted. | Five of six residents who suffered an unwitnessed fall did not have neurological assessments fully documented. | Ensure neurological observations are commenced and completed for all falls with possible or suspected head injury.  30 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 Low | Registered nurses and health care assistants who have completed the PSC medication competency administer medication. Once medication has been administered it is signed for on the medication signing sheet generated by the pharmacy. Not all medication administered was being signed for correctly. | One hospital resident was charted weekly Overstin cream and monthly Calciform. Both these medications were being signed as given for on the regular blister packaged signing sheet with each regular blister pack medication time. | Ensure that all weekly and monthly medication has a separate signing sheet  60 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Low | In the medication files reviewed the GP had prescribed all medication to be administered to the resident on admission. Four of ten medication charts reviewed evidenced that “as required” medications had been charted correctly. | i) Six out of ten medication charts reviewed did not have indications for use charted for as required medication.  ii) One of ten medication charts reviewed had an indication for use written by the registered nurse that was not signed by the GP | Ensure that all as required medication prescribing meets all contractual and legislative requirements.  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 | Assessment information is gathered from the resident, family, needs assessment service, the interRAI and from risk assessments conducted after admission and with a change in health condition. | i) The nursing assessments and long term care plan were not updated following a change in care level for one respite resident transferred to rest home care and one rest home resident transferred to hospital care.  ii) One of two rest home resident files reviewed documented the resident was admitted in October 2015 but was not commenced on the interRAI until February 2016. The second rest home file reviewed documented the resident was admitted in October 2015 and had not been commenced on the interRAI on the day of audit. | i) Ensure that nursing assessments are reviewed and the long term care plan is updated following a change in care level.  ii) Ensure that all interRAI assessments are completed and reviewed according to the contractual requirements  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Assessments are completed on admission, when the care plan is reviewed and with a change in health condition. Interventions were fully documented in the care plan for one rest home resident and one dementia resident files reviewed. Not all documented interventions were fully implemented or recorded. | i)Fifteen of fifteen wound care plans reviewed did not have a) an initial or ongoing wound assessments documented with each dressing change, b) specific interventions documented for management of the wound (frequency of dressing change, care of the wound bed) and c) evaluations of the wound management plan;  ii) Long term and short term care plan interventions did not fully describe the care requirements for two hospital residents with weight loss, one dementia resident (tracer) with a change in health condition. One hospital resident (tracer) whose care plan states is fully mobile however, the mobility and handling assessment notes state the resident no longer walks. This same resident (hospital tracer) is currently using a pressure relieving mattress however, this was not recorded in the care plan, and one rest home resident whose assessed falls risk assessment and use of a sensor mat had not been transferred to the long term care plan;  and iii) Monitoring, as requested in the care plan, was not documented for one hospital resident with weight loss who was to have food and fluid intake recorded and one hospital resident (tracer) requiring two hourly repositioning. | i) Ensure that wound care plans are fully documented and wound care documentation complies fully with the PSC wound management policy;  ii) Ensure that long term and short term care plans include all interventions required for residents noted in the progress notes are transferred to the care plan;  And iii) ensure that all monitoring is conducted and recorded as per care plan instructions.  60 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The recreational team leader completes an activity/recreational assessment on admission and develops an individualised recreation plan. Two of five resident files reviewed evidenced a recreational plan. One of two activity/recreational plans was reviewed at the same time as the long term care plan. | i) Three of five resident files reviewed did not have an activity/recreational assessment documented or an activity/recreational care plan completed.  ii) One of five files reviewed did not have the activity/recreational care plan reviewed in conjunction with the long term care plan. | i) Ensure all residents have a documented activity/recreational care plan  ii) Ensure that all activity/recreational care plans are reviewed in conjunction with the review of the long term care plan  90 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | The registered nurse undertakes a review of the long term care plan at least six monthly or with a change in health condition. The review process includes a review of the nursing assessments completed. Four of five long term care plan reviews evidenced a review of all recently completed nursing assessments.  The GP undertakes a review of the resident at least 3 monthly. Three of five files evidenced that three monthly reviews had been completed. | i) The care plan evaluation for one hospital resident completed in January 2016 documented no weight loss over the review period, however the weight monitoring recorded from November to January showed a 3kg weight loss.  ii) Two of five files sampled did not evidence that the three monthly GP reviews had been consistently completed within the required time frames. | i) Ensure a review of the long term care plan includes a review of all relevant assessments completed  ii) Ensure that the GP reviews the resident at least three monthly  90 days |

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

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

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

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

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End of the report.