

Presbyterian Support Central - Levin War Veterans

Introduction

This report records the results of a Certification 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:

Legal entity:	Presbyterian Support Central
Premises audited:	Levin Home for War Veterans
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: 19 May 2016 End date: 20 May 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:	69

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

Levin Home for War Veterans is owned by Presbyterian Support Central (PSC) and provides care for up to 80 residents at rest home, hospital and dementia level care. Occupancy on the days of the audit was 69 residents.

The service is overseen by a facility manager who is a registered nurse and is well qualified and experienced for the role. The facility manager is supported by a clinical nurse manager, a clinical coordinator and a regional manager. In addition central office provide oversight by a clinical director and support by nurse consultants. Residents and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against 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 residents and staff files, observations and interviews with residents, staff and management.

This audit has identified the following areas requiring improvement: Māori values and beliefs, information management systems, service provision, assessments, care planning, interventions, activities, evaluations and medicine management.

Consumer rights

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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The service complies with the Code of Health and Disability Consumers' Rights. Staff ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. Policies are implemented to support residents' rights, communication and complaints management. Care plans accommodate the choices of residents and/or their family/whānau. Staff and residents interviewed were familiar with the complaints management process.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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PSC Levin Home for War Veterans 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 to 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 for all roles within the service. 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The facility manager takes primary responsibility for managing entry to the service with assistance from the clinical nurse manager. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans. Residents 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. Medicines are stored and managed appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on-site under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. All bedrooms are single occupancy and some have ensuites. Those that do not have ensuites, share bathroom facilities. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are several lounge and dining areas throughout the facility. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

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.		Standards applicable to this service fully attained.
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There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit, there were no residents with restraint or enablers at PSC Levin Home for War Veterans. There is a restraint coordinator for the service, who is the clinical nurse manager. Restraint minimisation, enabler use and challenging behaviour training is included in the training programme.

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.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	36	0	7	2	0	0
Criteria	0	82	0	10	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)
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](#).

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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) has been incorporated into care. Discussions with seven healthcare assistants (two rest home, three hospital and two dementia level) identified their familiarity with the Code of Rights. Interviews with eleven residents (five rest home and six hospital) and nine family members (two rest home, three hospital and four dementia level) confirmed that the service functions in a way that complies with the Code of Rights. Observation during the audit confirmed this in practice.</p>
<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>Informed consent processes are discussed with residents and families on admission. The resident or their EPOA signs written consents. Nine resident files sampled (three rest home, two hospital, and four dementia level of care), demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Healthcare assistants and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files</p>

		sampled had a signed admission agreement.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. The information pack provided to residents at the time of entry to the service also provides residents and family/whānau with advocacy information. Interviews with healthcare assistants, residents and relatives informed they were aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Visitors were observed coming and going at all times of the day during the audit. Maintaining links with the community is encouraged. Activities programmes include opportunities to attend events outside of the facility. Discussion with staff, relatives and residents confirm residents are supported and encouraged to remain involved in the community and external groups.</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>There is a complaints policy to guide practice and this is communicated to residents and family members. The facility manager leads the investigation and management of complaints (verbal and written). A complaints register records activity. Complaint forms are visible around the facility. There were no documented complaints made in 2015 or 2016, year to date. The facility manager could describe the complaints management process and the process to follow that aligned with the PSC complaints management policy. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A copy of the complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Code of Rights leaflets are available in the front entrance of the facility. Code of Rights posters are on the walls in the hallways. Client right to access advocacy services is identified for residents and advocacy service leaflets are available at the front entrance foyer. Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and families are informed of the scope of services and any liability for payment for items</p>

		not included in the scope.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. The initial and ongoing assessment includes gaining details of people's beliefs and values. A tour of the facility confirms there is the ability to support personal privacy for residents. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Residents and families interviewed confirmed that staff are respectful, caring and maintain their dignity, independence and privacy at all times. The service has become an Eden registered home. A review of documentation, interviews with residents, relatives and staff highlighted how they demonstrate their commitment to maximising resident independence and make service improvements that reflect the wishes of residents.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	PA Low	<p>There are current policies and procedures for the provision of culturally safe care for residents identifying as Māori including a Māori health plan. The service has access to a cultural advisor with links to local iwi, Muaupoko Tribal Authority. Specialist advice is available and sought when necessary. Kaumatua and Kuia on the local Marae can be accessed by staff. The service reinstated the Maori Cultural Support Group, which had its first meeting in April 2016. The service's philosophy results in each person's cultural needs being considered individually. On the day of the audit, four residents identified as Māori. Not all residents who identified as Māori had their values and beliefs documented.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The cultural service response policy guides staff in the provision of culturally safe care. During the admission process, the facility manager or clinical nurse manager, along with the resident and family/whānau complete the documentation (link 1.1.4.3) Residents and family interviewed confirmed that they are involved in decision making around the care of the resident. Families are actively encouraged to be involved in their relative's care in whatever way they want and are able to visit at any time of the day. Spiritual and pastoral care is an integral part of service provision.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Discrimination, coercion, exploitation and harassment policies and procedures are in place. Code of conduct and position descriptions outline staff responsibilities in terms of providing a discrimination free environment. The Code of Rights is included in orientation and in-service training. Training is provided as part of the staff training and education plan. Interviews with staff confirm their understanding of discrimination and exploitation and could describe how professional boundaries are maintained. Discussions with residents identify that privacy is ensured.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the Health and Disability Services Standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects high levels of satisfaction with the services that are provided. Residents interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is an open disclosure policy. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Forms reviewed for April 2016 identified family were notified following a resident incident. Interviews with healthcare assistants inform family are kept informed. Relatives interviewed confirmed they were notified of any changes in their family member's health status. Discussions with residents and family members confirmed they were given time and explanation about services on admission. Resident meetings occur three times a year.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>PSC Levin Home for War Veterans is part of the Presbyterian Support Central organisation (PSC) and provides rest home, hospital and dementia level of care for up to 80 residents.</p> <p>The hospital services are predominantly delivered in three wings</p>

		<p>(Kowhai has 12 beds, Rimu has four beds and Totara Wing has 15 beds). The rest home services are predominantly delivered in two wings. The Pohutakawa wing has seven beds and Kauri Wing has 24 beds. There is an 18-bed dementia unit (Matai).</p> <p>Across the 62 rest home/hospital beds there are 12 dual purpose beds (six in the hospital area and six in the rest home areas).</p> <p>On the day of audit there were 69 residents (22 residents at rest home level including two rest home residents in dual-purpose beds in the hospital area [Totara wing]. There were 31 residents at hospital level including six hospital level residents in dual-purpose beds in the rest home area [two in Pohutakawa and four in Kauri wing]. There were 16 residents in the dementia area [Matai] including one resident on respite). All residents were on the ARCC agreement.</p> <p>The facility manager at PSC Levin Home for War Veterans commenced the role in February 2016 and ceased employment on the day following the audit. Advised that a facility manager from another PSC home will be providing interim management until a replacement has been appointed. The clinical nurse manager and clinical coordinator provide support to the facility manager. The clinical nurse manager has been in the position since November 2014 and has over 17 years' experience within the aged care industry. The clinical coordinator has been in the role for one year and has worked at the facility for five years. The service is also supported by a regional operations manager.</p> <p>PSC Levin Home for War Veterans has a 2015-2016 business plan and a mission and vision statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. PSC Levin Home for War Veterans is an Eden Alternative service and has achieved 10 principles of the Eden Alternative.</p> <p>The outgoing facility manager has maintained at least eight hours annually of professional development activities related to managing a care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service</p>	<p>FA</p>	<p>During the absence of an appointed facility manager, an acting facility manager will assume the role. The clinical nurse manager undertakes the role in the temporary absence (e.g. annual leave) of the facility</p>

<p>is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>manager and would be supported by the regional manager and the Presbyterian Support Central (PSC) office.</p>
<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>Presbyterian Support Central has an overall Quality Monitoring Programme (QMP) and PSC Levin Home for War Veterans participates in the external quarterly benchmarking programme. The service has a part-time (0.8FTE) quality coordinator. The senior team meeting acts as the quality committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and unit staff meetings. A range of other meetings is held at the facility. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms, which are being signed off and reviewed for effectiveness. The facility manager had an understanding of the contractual agreements and requirements. The regional manager has provided oversight and support to the facility manager on a weekly basis.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2015 and 2016 (year to date). Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the quality and staff meetings. The service has a health and safety management system and this includes a health and safety rep who has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health and safety meetings include identification of hazards and accident/incident reporting and trends.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The quality coordinator is responsible for document control within the service; ensuring staff are kept up to date with the changes. An organisational</p>

		<p>staff training programme is being implemented and based around policies and procedures.</p> <p>A resident satisfaction survey is completed annually. The 2015 survey informed an overall satisfaction with the service for residents at 88.7% and an overall satisfaction with the service for relatives at 93.5%.</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>	FA	<p>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 can be used for comparative purposes with other similar services.</p> <p>Senior team meetings and clinical focused meeting minutes include analysis of incident and accident data and corrective actions. A monthly incident/accident report is completed which includes an analysis of data collected. This is provided to staff. Follow-up assessments by a registered nurse include neuro observations for those residents that had an unwitnessed fall or hit their head. Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Three section 31 incident notification forms were completed in 2016 (all sighted) in relation to two matters referred to the police and one in relation to an outbreak. The appropriate action has been taken in relation to the matters outlined in the mandatory notifications that were sighted.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There is a human resources policies folder including recruitment, selection, orientation and staff training and development. The recruitment and staff selection process requires that relevant checks are completed. A copy of qualifications and annual practising certificates including registered nurses and general practitioners and other registered health professionals are kept. Nine staff files were reviewed (the facility manager, the clinical nurse manager, the clinical coordinator, one registered nurse, two healthcare assistants, one cook, one diversional therapist and one cleaner). All staff files reviewed</p>

		<p>including the appropriate employment and recruitment documents including annual performance appraisals. The service has an orientation programme in place. Care staff stated that they believed new staff were adequately orientated to the service. The facility manager and clinical coordinator completed an orientation programme that included two comprehensive orientation books that included checklists for completion.</p> <p>A training programme is being implemented that includes eight hours of annual education. The registered nurses and care staff attend PSC professional study days, which cover the mandatory education requirements and other clinical requirements. Attendance is monitored. The staff training plan includes regular sessions occurring as per the monthly calendar. The registered nurses have a journal club, which encourages ongoing learning and sharing.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster in place that provides sufficient and appropriate coverage for the effective delivery of care and support. There is at least one registered nurse on duty at all times. The facility manager and clinical nurse manager are employed full-time, Monday through Friday. Casual staff are available to cover staff illness. There is designated staff for kitchen, laundry, cleaning and activities. Residents and relatives interviewed advised that there are sufficient staff on duty at any one time and that staff are prompt to answer call bells and attend to resident's needs. The clinical nurse manager and clinical coordinator share the on call 24/7 clinical duties with the support of the facility manager and administrator for non-clinical issues.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>PA Low</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Not all amendments to care plans were signed and dated with the designation</p>

		recorded.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the facility manager and clinical nurse manager. The admission agreement form in use aligns with the requirements of the ARC contract. The facility manager and the office manager were both able to describe the 21-day absence provisions.</p> <p>Written information on the service philosophy and practices particular to dementia care, (including minimisation of restraint, behaviour management and the complaints policy) are included in the information pack.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.</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>	PA Low	<p>Eighteen medication files were sampled (six rest home, six hospital, six dementia). The service is planning to transfer to an electronic medication management system next week. The medication management policies comply with medication legislation and guidelines. Not all required medication checks had been completed. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboard.</p> <p>Medication administration practice complies with the medication management policy for the medication round sighted. Registered</p>

		nurses and healthcare assistants administer medicines. All staff that administers medicines are competent and have received medication management training. The facility uses a manually-packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Medical practitioners write medication charts correctly and there was evidence of three monthly reviews by the GP. Not all residents self-administering their own medication had completed the required competency assessments.
<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>	FA	<p>There is a fully 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 require special diets and the kitchen manager works closely with the RNs on duty. There was evidence that there are additional nutritious snacks available over the 24-hour period in the secure dementia unit.</p> <p>One kitchen staff member has completed the Level 3 National Certificate in Catering Services and three other kitchen staff members are currently completing this qualification. All kitchen staff have completed food safety training.</p> <p>The kitchen follows a rotating seasonal menu, which has been reviewed in April 2015 by an external 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 very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service records the reasons for declining service entry to residents should this occur and communicates this decision to residents/family/whānau and the referring agency. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Information on alternate placement options is given out.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	PA Low	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their</p>

gathered and recorded in a timely manner.		relative where appropriate. In the sampled appropriate acute assessment tools were not always evidenced. The interRAI assessment tool is implemented. Six of nine registered nurses are interRAI competent. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments but not all assessment information was transferred correctly to the long-term care plan. InterRAI assessments were not all reviewed at least six monthly.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	The long-term care plans reviewed did not all describe the support required to meet the resident's goals and needs. There was evidence of allied health care involvement in the resident files reviewed including a dietitian, speech and language therapist, podiatrist and wound care specialist nurses (Link 1.3.3.4) The interRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans were not in use for changes in health status. Resident documentation and activity reviews include Eden Alternative philosophy individualised assessments and Eden moments of interest. Staff interviewed reported they found the care plans easy to follow.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>Registered nurses (RNs) and HCAs follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse, hospice nurse and wound care specialist nurse (Link 1.3.3.4). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans were not completed for all wounds. There were 19 wounds on the day of audit. There were four in the rest home (one chronic ulcer and three skin tears) and fifteen wounds in the hospital (eleven skin tears, two blisters, one chronic ulcer, and one lesion). There was one hospital resident with a stage IV facility acquired pressure injury. The section</p>

		<p>31 notification had been completed. There were no wounds in the dementia unit. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses and HCAs demonstrated an understanding of the individualised needs of residents. Care plan interventions did not demonstrate interventions to meet all assessed residents' needs. There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weighs. Not all monitoring charts had been consistently documented.</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 service has achieved the 10 Eden principles, demonstrating a commitment to maximising resident independence and making service improvements that reflect the wishes of residents. PSC Levin Home for War Veterans activities programme (design, implementation and review) follows the Eden philosophy and is resident focused and individualised to reflect the resident wishes. The programme meets the recreational needs of rest home, hospital and dementia level care residents and reflects normal patterns of life. The programme is supported by a team of 19 volunteers.</p> <p>The service employs two recreational officers who are both diversional therapists that work five days per week. The weekend programme is delivered by the volunteers one of whom is also a diversional therapist. There is a set activity programme for the three different levels of care that is resident focused and is planned around meaningful everyday activities such as gardening, baking, reminiscing, feeding birds, assisting the hairdresser, dusting, tidying drawers and making own beds (if able). The dementia files reviewed did not evidence a 24-hour activity care plan.</p> <p>There is evidence that the residents have regular input into review of the wider programme (via Eden circles and resident surveys) and this feedback is considered in the development of the resident's activity programme. Residents interviewed expressed a high level of satisfaction with the program and confirmed that they felt listened to</p>

		<p>and had input into the development of their individual activity plan.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). The documentation in the resident files sampled was full and reflected the interests, hobbies and uniqueness of each resident. Relatives interviewed advised that the activity program was interesting with lots of choice and the residents were encouraged to participate. Residents and families interviewed evidenced that the activity programme had a strong focus on maintaining independence and reducing boredom.</p> <p>In the files reviewed the recreational plans had been reviewed six monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plans were not all evaluated at least six monthly or earlier if there is a change in health status (link 1.3.3.3). There was at least a three monthly review by the GP. Not all changes in health status were documented and followed up. Reassessments have been completed using interRAI LTCF for all residents who have had a significant change in health status since 1 July 2015. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files Link 1.3.3.4). The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. The staff provided examples of where a resident's condition had changed and the resident was reassessed (Link 1.3.8.3)</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous</p>	FA	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in</p>

<p>Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>relevant policy. Gloves, aprons and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and were all stored safely throughout the facility. Safety data sheets are available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness, which expires in September 2016. PSC have made significant investment in upgrades in the past two years including upgrading the bedrooms, building a hairdressing salon, replacing flooring, furniture and curtains, landscaping and installing new heating and cooling systems. A maintenance contractor undertakes the reactive maintenance and works 20 hours per week. The maintenance contractor also looks after the grounds and is available after-hours for emergencies. Scheduled maintenance is arranged and managed through PSC head office. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. External areas are maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>The dementia area has recently had improvements made to the outdoor area, which is easy to access and is well maintained. There are also quiet low stimulus areas that provide privacy when required.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. Some bedrooms have ensuites and other residents share communal toilets and showers. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed</p>	<p>FA</p>	<p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p>

areas appropriate to the consumer group and setting.		
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large central dining room for the rest home and hospital residents. There are several lounge areas and sitting rooms in the hospital and rest home. The dementia unit has one large lounge and a smaller sunny lounge area that looks over the internal courtyard. There is a separate dining area and activity area.</p> <p>There is adequate space throughout the facility to allow maximum freedom of movement while promoting safety for those that wander. There is adequate space to allow for group and individual activities.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are dedicated cleaning staff to clean the facility. The cleaning staff have all completed the Level 2 Certificate in cleaning. Staff have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme. Residents interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>Laundry staff complete all laundry on-site through a newly implemented sustainable laundry system that reduces water usage and electricity costs. Laundry staff are enrolled in a Level 2 Laundry Certificate qualification. Residents interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. 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. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. This includes 2500 litres of emergency water and two diesel powered generators. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place. The staff interviewed were able to describe the emergency management plan and how to implement this.</p>

		<p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>PSC Levin Home for War Veterans has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The infection control role is currently shared by the clinical coordinator and another registered nurse. The infection control coordinators have support from all staff including the quality management committee (infection control team). Minutes are available for staff. Spot audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection control role is currently shared by the clinical coordinator and another registered nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurses have good support from the senior management team, the quality coordinator, the PSC clinical director and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and</p>	FA	<p>There are PSC infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have</p>

procedures are practical, safe, and appropriate/suitable for the type of service provided.		been reviewed and updated.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control coordinators have both completed a Level 7 paper in Infection Control. The infection control coordinators attend an infection control peer support forum every three months with other facilities in the area. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Infection surveillance is an integral part of the infection control programme and is described in PSC Levin Home for War Veterans infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used (Link 1.3.5.2). Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager. An outbreak of influenza in April 2015 was appropriately managed.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There is a restraint policy in place that states the organisations philosophy to restraint minimisation. The policy identifies that restraint is used as a last resort. On the day of audit, there were no residents with restraint or enablers at PSC Levin Home for War Veterans. Staff are trained in restraint minimisation and the management of challenging behaviour. The clinical nurse manager is the restraint coordinator for the service.

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 1.1.4.3</p> <p>The organisation plans to ensure Māori receive services commensurate with their needs.</p>	PA Low	<p>Registered nurses determine the cultural and/or spiritual needs of each Māori resident in consultation with the resident, family and significant others as part of the admission process. This procedure was not documented for two residents who identified as Māori.</p>	<p>Two Māori resident files reviewed did not evidence documentation of the resident’s Māori values and beliefs.</p>	<p>Ensure cultural values and beliefs are identified for Māori residents.</p> <p>90 days</p>
<p>Criterion 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	<p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Residents’ files are protected from unauthorised access by being locked away in the nurses’</p>	<p>i) Four of five long-term care plans had additions and alterations made that were not signed or dated and where the alterations were signed no designation was documented ii) Four of fifteen wound care plans were not signed and where amendments made to the wound care plans where</p>	<p>i-ii) Ensure any alterations or amendments to the long-term care plan or wound care plans are signed and dated and the designation is recorded.</p>

		stations.	signed no designation was recorded.	90 days
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Low	The pharmacy and registered nurses are required to undertake regular checks of the medication. Not all mandatory medication checks had been completed within the required timeframes.	The pharmacy and registered nurse medication checks had not been consistently completed within the required timeframes.	<p>Ensure that all medication checks are completed to comply with all legal and contractual requirements.</p> <p>60 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	Three rest home residents self-administer their own medicines. The residents who are self-medicating are required to complete a competency assessment every three months. This was evidenced in two of three medication files reviewed.	One of three rest home residents self-medicating had not completed the required self-medication competencies three monthly.	<p>Ensure that all residents who self-medicate complete the required competency assessments.</p> <p>60 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Low	The registered nurses are responsible for completing the initial assessments and completing the long-term care plan within 21 days of admission. Seven of nine long-term care plans had been completed within three weeks of admission. The GP completes the initial medical assessment and this was evident in eight of nine files reviewed. The registered nurses advised that they undertake a review of the long-term care plan at least six monthly and this	<p>i) Two files reviewed (one dementia and one hospital) did not have the long-term care plan developed within three weeks of admission;</p> <p>ii) One files reviewed (one dementia) did not have the initial GP assessment documented; and</p> <p>iii) Three files sampled (one rest home, one hospital and one dementia) did not have the long-term care plan reviewed at least six monthly</p>	<p>i) Ensure that long-term care plans are completed within the required timeframes.</p> <p>ii) Ensure that the initial GP assessment is fully documented.</p> <p>iii) Ensure that long-term care plans are evaluated six monthly.</p>

		was evidenced in six files reviewed		60 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Low	The registered nurse is responsible for all aspects of care planning and clinical follow up. Not all residents referred to allied health care professionals had been followed up and not all changes in health status noted by an RN had been reviewed.	<p>i) One rest home resident was referred to the orthotics depart by the wound care specialist nurse in November 2015. There was evidence the referral had been sent however, there was no documented evidence that the referral had been received or followed up until April 2016.</p> <p>ii) One dementia resident was noted in the progress notes by an RN to be urinating frequently and had leukocytes in the urine. No documented evidence of a reassessment or follow up was located.</p>	<p>i-ii) Ensure that all changes in health status and referrals to allied health professionals are actioned and followed up in a timely manner.</p> <p>60 days</p>
<p>Criterion 1.3.4.2</p> <p>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.</p>	PA Low	The registered nurse is responsible for the review of all completed assessments and uses this information to inform the development of the care plan. Not all residents with pain, had pain assessments documented.	Four of nine files reviewed (two rest home and two hospital) with pain noted in the progress or medical notes had no regular pain assessments documented.	<p>Ensure that pain assessments are documented for residents experiencing pain.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by</p>	PA Low	The registered nurse is responsible for documenting the resident's plan of care. Seven of nine residents had a care plan documented for their identified care needs. However; in the files sampled, interventions for all	<p>i) Interventions were not documented for a) two residents (one rest home and one hospital) with suprapubic catheters, b) one rest home resident with a history of PR bleeding and diverticulosis c) one rest home</p>	<p>i-iii) Ensure that care plans fully described the required interventions for all assessed care needs.</p>

<p>the ongoing assessment process.</p>		<p>assessed care needs had not been documented. However, in the files sampled interventions for all assessed care needs had not been documented.</p>	<p>resident with recurrent UTI's.</p> <p>ii) One rest home resident with a UTI did not have a short-term care plan documented for this acute change in health condition; and</p> <p>iii) Specific interventions for weight management were not documented for a) three residents (one rest home, one hospital and one dementia) with weight loss of 3kgs over the past three months, b) one rest home resident with a weight loss of 5 kgs over five months who now weighs 34 Kgs c) one rest home resident who had been seen by the dietician for weight gain.</p>	<p>60 days</p>
<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>	<p>PA Moderate</p>	<p>The registered nurses interviewed confirmed that interventions are documented in the care plan for all assessed care needs with exceptions (link 1.3.5.2). Monitoring records were in place however, not all required monitoring was consistently documented. Wound assessment, monitoring and wound management plans are in place, however wound care documentation was not all fully completed.</p>	<p>i) Monitoring records were not consistently documented for a) one resident on 30 minute checks (dementia tracer), b) two hospital residents on fluid balance charts had not had the input or output records totalled and c) one resident on two hourly turns (hospital tracer.), d) a rest home resident with a suprapubic catheter did not have all catheter changes documented on the catheter change form.</p> <p>ii) Six of twenty initial wound assessments (one rest home and five hospital – including hospital tracer,) did not fully describe the wound.</p> <p>iii) One of twenty wounds (rest home) did not have a management plan</p>	<p>i) Ensure that all required monitoring is consistently documented.</p> <p>ii-iv) Ensure that all wound documentation is fully completed.</p> <p>60 days</p>

			documented. iv) 16 of 20 wounds (four rest home and sixteen hospital - including hospital tracer) did not document the wound healing with each dressing change.	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	The recreational programme offered in the dementia unit is varied and interesting and each resident has an individualised programme. The dementia resident files reviewed did not evidence an activity plan that covered the 24-hour time period.	Three of three resident files sampled for residents in the secure dementia unit did not have activity plans documented to cover the 24-hour period.	<p>Ensure that all residents in the secure dementia unit have a 24-hour activity care plan documented.</p> <p>90 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Low	The registered nurses interviewed confirmed that they review and update the care plan when there is change in health condition or at least six monthly. Not all interventions noted in the evaluation comments were transferred to the care plan.	<p>i) One of nine files sampled did not have the long-term care plan reviewed following a change in assessed care level from rest home to hospital level of care;</p> <p>ii) Interventions noted in the evaluations were not transferred to the long-term care plan for one resident with a chronic skin condition (dementia tracer).</p>	<p>i) Ensure that the long-term care plan is updated with a change in assessed care level; and</p> <p>ii) Ensure that all interventions noted in the care plan evaluations are transferred to the long-term care plan</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.

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End of the report.