# CHT Healthcare Trust - Carnarvon Private Hospital

## Introduction

This report records the results of a Provisional 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:** CHT Healthcare Trust

**Premises audited:** Carnarvon Private Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric)

**Dates of audit:** Start date: 8 September 2016 End date: 9 September 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:** 30

# 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.

## General overview of the audit

Carnarvon Private Hospital Ltd is owned and operated by the Carnarvon Hospital Trust Board. The service provides care for up to 40 residents requiring hospital (geriatric and medical) level care. On the day of the audit, there were 30 residents.

This provisional audit was undertaken to establish the level of preparedness of a prospective provider to provide a health and disability service and to assess the level of conformity of the current provider prior to the facility being purchased. The 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, relatives, staff and management.

The facility manager is a registered nurse (RN) and has been in the role for the last four months. She is supported by a clinical manager (new to the role) and a charge nurse (RN).

The prospective purchaser is an experienced aged care provider. They currently have 14 aged care facilities. They have comprehensive policies and procedures to guide staff. It is CHTs intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership, which will see the implementation of CHT policies and procedures and quality system being implemented at Carnarvon. The prospective purchaser is yet to confirm if there will be changes in management and staffing.

The service has addressed the shortfalls from the previous surveillance audit around medication management, nutrition and fluid management.

This audit has identified a number of areas for improvement around open disclosure, governance, quality and risk, audits, corrective actions, hazard register, hazard management, human resources, assessments, care planning, interventions, evaluations, testing and tagging, and restraint management.

## Consumer rights

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with dignity and respect. Written information regarding consumers’ rights is provided to residents and families during the admission process. The residents' cultural, spiritual and individual values and beliefs are assessed on admission and are being met by the service. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

The new owners of Carnarvon Private Hospital Ltd are experienced providers of aged care services. CHT was formed in 1962 and is a charitable trust. The trust board is supported by a chief executive and a finance manager. A CHT area manager will oversee the implementation of CHT policies and procedures and quality systems.

There is a documented system for the collation, trending, analyses and evaluation of quality and risk data that is regularly collected. The risk management programme documents a process for managing adverse events and health and safety processes.

Residents receive services from suitably qualified staff. An orientation programme and ongoing education and training are in place for all staff.

Registered nursing cover is provided 24 hours a day, seven days a week. The residents’ files are appropriate to the service type.

## Continuum of service delivery

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the content of care plans is discussed with them at multi-disciplinary care planning review meetings. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

Carnarvon Private Hospital Ltd has a current warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. The service has implemented policies and procedures for civil defence and other emergencies. Monthly fire drills are conducted. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounges and dining areas and small seating areas. There is a designated laundry and cleaner’s room. External garden areas are accessible with suitable pathways, seating and shade provided.

## Restraint minimisation and safe practice

A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently 12 residents requiring restraints and eight residents using enablers. Staff are trained in restraint minimisation and challenging behaviour management.

## Infection prevention and control

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. Infection control data is benchmarked against other aged care facilities via the district health board benchmarking programme.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 38 | 0 | 8 | 1 | 3 | 0 |
| **Criteria** | 0 | 82 | 0 | 11 | 5 | 3 | 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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | There is an implemented policy on residents’ rights to guide practice. Discussions with care staff (four caregivers, two registered nurses (RNs), one charge nurse, one clinical manager, one activities assistant, one cook, one maintenance, one laundry staff, and one facility manager) confirmed their understanding of the Code of Health and Disability Consumers’ Rights (the Code). Interviews with six residents and three relatives confirmed the service is provided in line with the Code. Staff training on the Code begins during their orientation to the service and continues regularly as an in-service topic. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent and advanced directives were recorded as evidenced in the six resident files reviewed, which included (one respite resident on a young person’s disability contract (YPD). Staff interviewed advised that family involvement occurs with the consent of the resident. Residents interviewed confirmed that information was provided to enable informed choices and that they were able to decline or withdraw their consent. Resident admission agreements were signed in all files sampled. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents are provided with a copy of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights and HDC Advocacy Services pamphlets on entry. HDC Advocacy pamphlets are displayed adjacent to the complaints form. Advocacy contact details are documented on the complaints forms. Interviews with the facility manager and staff described how residents are informed about advocacy and support. Residents and families identified that the service involves them in decision-making. They confirmed that they are aware of their right to access advocacy support. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | All families interviewed stated they could visit at any time and that they are encouraged to be involved with the service and care. Visitors were observed coming and going during the audit. The activities programme encourages links with the community. Activities include opportunities to attend events outside of the facility. Interviews with the residents confirmed that the activity staff help them access the community. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives during entry to the service. Discussions with residents and families confirmed they were provided with information on complaints during their entry to the service. Complaints forms are located in a visible location at the entrance to the facility. Residents and families confirmed that they are comfortable speaking with the facility manager or clinical manager if they have a concern and that concerns are dealt with promptly.  A record of complaints is maintained by the facility manager using a complaints’ register. Seven complaints received since May 2016 (year to date) were reviewed and reflected evidence of responding to the complaint in a timely manner with appropriate follow-up action taken. All documentation associated with the complaint was held in the complaints register. The complaints were signed off by the facility manager as resolved. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The Code posters and brochures are displayed in English and in Māori in public areas of the facility. The information pack given to prospective and admitted residents and their families include pamphlets on the Code and the Health and Disability Advocacy Service. The admission agreement contains information relating to the rights of residents. Interviews with residents and family confirmed that residents’ rights were explained during the admission process. They also confirmed that residents’ rights are being upheld by the service.  The prospective purchaser, CHT are familiar with the Code of Consumer Rights and understand how to ensure this is adhered to and implemented. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There is an implemented policy supporting the privacy of residents. Consent processes and visual privacy are upheld. Privacy signage and locks are on communal toilets and shower doors. Discussions with residents and relatives confirmed their privacy is respected with examples provided.  The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Spiritual, religious, and cultural information is gathered during the entry process and is sufficient to support responding to the individual needs of the residents. A satisfaction survey was sent out in late August 2016 and the survey forms were still being returned by the residents on the day of audit. Six residents’ files reviewed confirmed that cultural and/or spiritual values and individual preferences were identified.  Residents are supported and encouraged to maintain their independence, confirmed in interviews with staff.  The abuse/neglect policy includes definitions and the process for reporting to ensure resident safety. Abuse and neglect training is included in the staff orientation programme and continues as a regular in-service topic. The facility manager advised that there have been no reported incidents of abuse or neglect involving the residents. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | There is a Māori health care plan in place. There were no residents who identify as Māori on the day of audit. Discussions with staff confirmed their understanding of the cultural needs of residents, including the importance of involving whānau in the delivery of care. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | A culturally appropriate service is provided, which includes assessing residents’ needs on admission. Even if family cannot be present during the admission process, the initial assessment on admission is reviewed with family. Individual values and beliefs are identified through the assessment and care planning process. Family are invited to be part of the care planning process, providing the opportunity to be involved in all aspects of care delivery. Staff and family are available as interpreters if needed. There are six residents at the facility where English is their second language. Families and residents interviewed expressed their satisfaction with the services that the residents are receiving. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Policies outline the service’s responsibilities to ensure residents are not subjected to discrimination, coercion, harassment, and sexual or other exploitation. Education and training is provided to staff, beginning during their orientation to the service, including professional boundaries, code of conduct, abuse and neglect and residents’ rights. Residents and families interviewed confirmed that they do not feel they are discriminated against. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The facility manager and clinical manager could describe the principles of quality improvement. Registered nursing staff are available seven days a week, 24 hours a day with two registered nurses available on the am shift and one registered nurse on afternoon and night shift. This is in addition to the clinical manager who is available Monday - Friday. A general practitioner (GP) reviews residents identified as stable every three months, with more frequent visits scheduled for those residents whose condition is not deemed stable.  The service receives support from the district health board and local hospice service. Examples include visits from the mental health team, nurse specialists; and palliative care nursing visits by the community hospice. A physiotherapist is onsite eight hours each week.  There is a regular in-service education and training programme for staff that exceeds contractual requirements. Staff competency assessments are completed for a range of topics, including (but not limited to) medication, manual handling, and syringe driver. All caregiver staff receive supervision by registered nurses.  The service has maintained strong links with the local community and encourages their active residents to remain independent with examples provided. Residents interviewed spoke positively about the care and support provided. Care staff interviewed have a sound understanding of the principles of aged care and state that they are supported with their ongoing professional development. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Policies and procedures relating to accident/incidents and open disclosure identify staff responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whanau is recorded in the progress notes. Communication with family was not always evidenced following an adverse event. During the audit the families interviewed, advised that they are kept informed when their family member’s health status changes.  Contact details of available interpreters are available. Staff and family assist as they are able.  Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry, of the scope of services and any items they have to pay for that are not covered by the agreement. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | This provisional audit was conducted to assess the preparedness of the prospective owners and included an interview with a CHT Healthcare Trust Area Manager, a review of the CHT Healthcare Trust transition plan and interviews with the current facility manager, clinical manager and care staff.  The prospective owners, CHT Healthcare Trust, own and operate 14 other aged care facilities. CHT Healthcare Trust has comprehensive policies and procedures to guide staff. It is CHT Healthcare Trust’s intention to facilitate a smooth transition between owners and to minimise disruption to staff and residents. The organisation has a plan for the transition and change of ownership, which will see the implementation of the CHT Healthcare Trust organisational structure and their policies and procedures. While the required contractual nursing hours per resident per day will be adhered to, the staffing structure has not yet been finalised, as interviews with current staff have not yet been completed.  Carnarvon Private Hospital Ltd is a 40-bed hospital level care facility. The facility is currently owned by The Carnarvon Hospital Trust Board, which has three directors. On the day of audit, there were 30 residents, including three respite care residents (including one young person with disability), one palliative care, two young persons with disability, and 24 residents admitted under the ARRC. A facility manager is onsite five days per week.  The facility manager has documented a new strategic and business plan and a quality and risk management plan for 2016 – 2018. These plans have not yet been implemented. No evidence could be located to demonstrate that the strategic plan for 2012 – 2017 had been reviewed annually or that these plans were being followed. An overall mission statement and philosophy are in place.  The facility manager has been in this role for four months and advised that they will continue to manage the facility through the change in ownership. The facility manager is a registered nurse with a current practising certificate, and has previous aged care management experience.  The clinical manager has been in the role for 6 weeks and has had previous roles as a charge nurse in the adult treatment and rehabilitation areas in the DHB.  The facility manager keeps up to date with the aged care sector through regular attendance at New Zealand Aged Care provider forums and district health board forums. The facility manager and the clinical manager have maintained over eight hours of professional development relating to managing aged care facilities. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | The facility manager is supported by a clinical manager and a charge nurse. The clinical manager is responsible for the day-to-day operations in the facility manager’s absence. |
| 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 High | A 2016 - 2018 strategic and business plan and a risk management plan are documented but not yet fully implemented (link 1.2.1.1). Interviews with the facility manager reflect an understanding of quality and risk management systems. However, documentation reviewed does not reflect all areas of the quality and risk management system are fully implemented. A number of shortfalls were noted around the implementation of the current quality programme. As the new owners, CHT Healthcare Trust will introduce their strategic business plan and quality management systems as part of their transition plan.  Policies and procedures, and associated documents provide a pathway for the service to meet accepted good practice and adherence with relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The facility manager advised the service has recently purchased a new set of policies and procedures and the service is currently transitioning to these. Changes to organisational documents are not consistently communicated to staff. A document control system is in place.  Data collected (eg, falls, medication errors, wounds, skin tears, challenging behaviours) are collated. Shortfalls were noted in the analysis and trending of data and the communication of this data to staff. Internal audits are not being completed as documented in the audit schedule and corrective actions were not being identified. The service benchmarks infection control data externally.  A health and safety programme is documented. Health and safety is an agenda item at staff meetings bi-monthly (minutes sighted). Staff interviewed were able to describe the principles of hazard management. Staff orientation includes health and safety. The facility has achieved tertiary level for ACC Workplace Safety Management Practices (expiry March 2017); however, shortfalls were noted around the implementation of the Health and Safety programme.  The service has a high incidence of falls, however there was no evidence of a falls reduction strategy for the service. |
| 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 Low | Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. The resident is reviewed by the RN at the time of the event. Seven incident forms were reviewed and not all sections the accident and incident form were fully completed. Not all families were notified of the untoward event (link 1.1.9.1). The events were documented in the residents’ progress notes, however the interventions required for acute changes were not documented in a care plan (link 1.3.5.2). There were shortfalls around the documentation of incident/accident forms for pressure injuries.  Discussions with the facility manager and clinical manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications. There is one matter before the coroner related to a notification made in 2014. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Human resources policies address recruitment, orientation and staff training and development. Seven staff files were randomly selected for review (one caregiver, one registered nurse, one clinical manager, one cook, one cleaner, one activities assistant, one maintenance). Not all files reviewed included evidence of the required recruitment documentation, however annual performance appraisals were all completed as required.  The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed stated that new staff are adequately orientated to the service. Current annual practising certificates were sighted for the registered health professionals.  There is an annual education and training schedule that exceeds eight hours per annum. Additional training is provided at handover on a range of clinical topics. There is a dedicated education role 20 hours per week. Education and training for registered nursing (RN) staff is also accessed at the DHB. Five of nine RNs have completed their InterRAI training. Two yearly chemical safety training is in place for staff who handle hazardous cleaning chemicals. Staff complete competencies.  NZQA training is available for care staff. The staff educator is an enrolled nurse (EN) and works 20 hour per week. She advised that she supports staff to achieve their National Certificate and the majority of caregivers have this now. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Staffing levels meet contractual requirements. The facility manager and clinical manager are registered nurses who are available during weekdays. Adequate on-site RN cover is provided 24 hours a day, seven days a week with two RNs and the clinical manager covering the am shift and one RN covering the pm and night shift. RNs are supported by sufficient numbers of caregivers. Activities staff provide a five day a week cover. Interviews with the residents and relatives confirmed staffing overall was satisfactory.  The new owners plan to review the current staffing plan as part of the transition plan. CHT Healthcare Trust advised that whilst the required contractual nursing hours per resident per day will be adhered to, the staffing structure has not yet been finalised. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident files are appropriate to the service type. Residents entering the service have relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is developed in this time.  Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access by being held in secure metal filing cabinets. Archived records are stored securely on the premises.  Individual resident files demonstrate service integration. Entries are legible, timed and signed by the relevant caregiver or health professional. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are assessed prior to entry to the service by the needs assessment team, and an initial assessment was completed on admission. The service has specific information available for residents and family at entry and it included associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARRC contract and exclusions from the service were included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | A standard transfer notification form is utilised when residents are required to be transferred to the public hospital or to another service. The charge nurse verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families were involved for all exit or discharges to and from the service. |
| 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. | FA | The medication management policies and procedures comply with medication legislation and guidelines. The service uses an electronic/computerised medication management system. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Residents’ medicines are stored securely in the medication room/cupboard. Medication administration practice complies with the medication management policy for the medication round sighted.  Registered nurses and enrolled nurses administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication 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. One resident self-administers their own medicines and the documentation was correctly recorded and a competency assessment completed. The service uses standing orders and the documentation and practices comply with legislative requirements. |
| 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 are prepared and cooked on site. There is a four weekly rotating menu, which had been reviewed by a dietitian. All food observed in the fridges and freezers was dated. Meals are prepared in a well-appointed kitchen adjacent to the dining room and served directly to residents. For those residents who prefer or require to have their meal in their room, meals are plated covered and transported to residents’ rooms. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Meat sighted in the freezer was labelled and dated.  Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the registered nurse or charge nurse. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a GP/dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The reason for declining service entry to residents to the service would be recorded on the declined entry form, and when this has occurred, the service stated it had communicated to the resident/family and the appropriate referrer. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Low | All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which formed the basis of resident goals and objectives. The InterRAI assessment tool was completed in five of five permanent resident files sampled. One resident was admitted for respite care and did not require an InterRAI assessment. Not all files reviewed evidenced that the outcomes of the InterRAI assessment were used to inform the care planning process. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA High | The RNs are responsible for all aspects of care planning. The InterRAI assessment process informs the development of the resident’s care plan (link 1.3.4.2). The care plans reviewed demonstrated service integration and input from allied health. Not all care plans reviewed included specific interventions for all identified care needs. Care plans were not always documented to reflect acute changes in health status. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Family/whānau members interviewed confirmed the care delivery and support by staff is consistent with their expectations. |
| 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 | Turning charts and weight monitoring charts sighted indicate that overall implementation was occurring. There were examples where pain was being assessed and pain-monitoring charts were in use, however this was not consistently completed where required. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.  Wound monitoring and wound management plans were in place for six wounds including two pressure areas. Wound documentation did not include a comprehensive assessment and monitoring forms reviewed did not document the timeframe for review. The wound management plans did not include sufficient detail to direct treatment. The RNs have access to specialist nursing wound care management advice through the district nursing service. On interview, the facility manager advised that there was one pressure injury in the facility, however, following review of wound folders and on interview with caregivers and registered nurses, there were two facility acquired pressure injuries identified. The RN stated there was one stage-3 pressure injury and one stage-1 pressure injury. The audit team observed dressing changes to confirm the correct pressure injury stage classification.  Interviews with registered nurses, clinical manager, charge nurse and caregivers demonstrated an understanding of the individualised needs of residents and report that two hourly turns occur and pressure injury prevention resources such as alternating air wave mattresses, cushions, and Spenco pressure relieving Bootees have been implemented. There were examples where food and fluid charts were used as directed by RNs (link 1.3.5.2). |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities coordinator provides an activities programme Monday to Friday each week with the caregivers implementing the programme at weekends. The programme is planned monthly and residents received a personal copy of planned monthly activities. Activities planned for the day were displayed on noticeboards around the facility. An activity plan was developed for each individual resident based on assessed needs. Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service hires a mobility van to take residents on trips and outings three times per month. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plans were evaluated but not in the required timeframes (link 1.3.3.3). There was at least a three monthly review by the GP. Reassessments have been completed using InterRAI but not in the required timeframe (link 1.3.3.3). The RN completed care plan reviews are signed by the registered nurse. Short-term care plans sighted (infections) were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service initiates a change to the care plan. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family/EPOA are involved as appropriate when referral to another service occurs. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There is a waste and hazardous substance safety policy. Management of waste and hazardous substances is covered during orientation of new staff and chemical safety education is completed annually. All chemicals are stored in locked cupboards. Safety datasheets and product wall charts are available. Approved sharps containers are used. These are easily identifiable. Gloves, aprons and visors are available for staff use and staff were observed wearing appropriate protective equipment when carrying out their duties. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building holds a current warrant of fitness. Reactive and preventative maintenance occurs and there is a planned maintenance programme. There is a designated maintenance person. Outside contractors check medical equipment and hoists annually. Hot water temperatures are monitored and maintained between 43-45 degrees Celsius. There are contractors for essential services available 24/7. Electrical testing and tagging has not been completed for all equipment in use.  The living areas and hallways are carpeted and vinyl surfaces exist in bathrooms/toilets and the kitchen. The corridors are adequate and there are handrails in all corridors. Residents were observed moving freely around the areas with mobility aids where required. There are external areas and gardens, which are wheelchair accessible. There is outdoor furniture and seating and shaded areas.  The staff interviewed stated that they have all the equipment referred to in care plans to provide care. CHT Healthcare Trust have no current plans for environmental changes at this time. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | There are four rooms with ensuites and one room with a toilet. There are adequate numbers of communal toilets and showers. There is appropriate signage, easy clean flooring and fixtures, and handrails appropriately placed. Privacy is maintained at all times (observed). |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | There are two double rooms and the other rooms are all single. The rooms are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Residents are encouraged to personalise their rooms if desired. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | The communal areas include lounges and dining areas. These are large enough to cater for activities. Residents are able to move freely and safely and furniture is arranged to facilitate this. There is adequate space to allow for individual and group activities to occur. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There is a cleaning policy and cleaning schedules in place. All cleaning chemicals are clearly labelled. Personal protective equipment is available in the sluice and treatment rooms. The cleaning trolleys are stored safely when not in use. Safety datasheets are available. Cleaners were observed to be wearing appropriate protective wear when carrying out their duties.  There is a laundry policy. There is a defined clean/dirty area within the laundry. The laundry is locked when not in use. Safety datasheets are on the wall. There is personal protective equipment in the laundry. The laundry staff were observed to be wearing appropriate protective wear when carrying out their duties. There are adequate linen supplies – sighted. Laundry and cleaning staff have attended chemical safety training. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has a fire and emergency procedures manual. There is an established current evacuation scheme. The service has documented fire evacuation drill dated July 2016. The facility manager stated that they are completing monthly fire drills over the next three months and fire safety training has been provided to ensure staff are fully aware (link 1.2.3.9). There is a staff member with a first aid certificate on each shift. A call bell light over each door and a panel in each corridor alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. There is a current emergency plan and the facility has the ability to remain self-sufficient in the event of an extreme emergency. Civil defence and first aid resources were available. There is sufficient food for at least three days, which is kept in the kitchen and rotated as required. There are extra blankets, continence products, gas cooking and torches available. Sufficient water is stored for emergency use and alternative heating facilities is available. Emergency lighting is installed. Security checks have been conducted by staff each night. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All bedrooms and communal areas are well ventilated and light. The temperature of the facility is comfortable. All bedrooms have external windows, which let in natural light. |
| Standard 3.1: Infection control management  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. | FA | The facility 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. A registered nurse is the designated infection control coordinator with support from the clinical manager. Minutes are available for staff. Infection control 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. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team has good external support from the local laboratory infection control team 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. |
| Standard 3.3: Policies and procedures  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 procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | There are 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 been reviewed and updated. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | 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 coordinator has completed infection control training. 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. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly. The facility participates in quarterly benchmarking of infections via the district health board. Outcomes and actions are discussed at combined quality meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical manager. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were twelve residents with restraint and eight residents with an enabler. Enabler use is voluntary. Staff interviews and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of combined/quality meetings. The clinical manager is the designated restraint coordinator. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The clinical manager is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. |
| 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 is required to complete 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 three restraint and two enabler 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, not all residents using a restraint had the required assessment documentation, and consents completed (link 2.2.3.4). |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | PA High | The restraint minimisation manual identifies that restraint is only to be put in place where it is clinically indicated and justified and approval processes are obtained/met. There is an assessment form/process that is to be completed for all restraints and enablers. There were shortfalls noted with assessments, restraint care plans and the restraint monitoring in the files reviewed. The service has a restraint and enablers register that was not current. This was addressed by the clinical manager on day one of audit. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | PA Low | The restraint coordinator has recently introduced monthly individual review of residents on restraint. Restraint practices are also reviewed by the facility restraint coordinator at combined quality meetings. Evaluation timeframes are determined by policy and risk levels. The duration of restraint episode as to whether this was for the least amount of time required was not evidenced to be evaluated. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | FA | The service reviews restraint as part of the internal audit and reporting cycle. The facility has recently introduced monthly individual resident restraint audits. Reviews are completed six monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly combined/quality meetings. |

# Specific results for criterion where corrective actions are required

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

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

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | The accident/incidents, and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Seven incidents/accident forms were viewed. There were two different accident/incident forms in use and not all forms included a section to record family notification. Not all notifications to families following an adverse event were recorded in the progress notes. | Six of seven incident forms reviewed did not evidence communication to families/EPOAs following an untoward event. | Ensure that communication with families/EPOA occurs following untoward events and this is clearly documented.  90 days |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | The service has a 2012 - 2017 strategic business plan. No evidence could be located to show that this plan had been reviewed since 2014 and the facility manager advised they were not implementing this document. The facility manager documented a 2016 - 2018 strategic business plan and a risk management plan (developed June) which have not yet been implemented. | i) Currently the strategic business plan or risk management plan are not being implemented or followed.  ii) There was no documented evidence to identify the 2012 – 2017 strategic business plan having had an annual review since 2014. | i) Ensure that there is a strategic business plan and a risk management plan in place and these plans are fully implemented.  ii) Ensure that the strategic business plan and the risk management plan are reviewed at least annually.  90 days |
| Criterion 1.2.3.1  The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Moderate | The service has a documented quality and risk management system. This system has not been fully implemented. The manager had purchased a set of internal audit tools. These did not align to current policies and procedures. While some of these internal audits have been completed, the results were never reported or followed through. | i) The documented strategic and business plan and risk management plan are not fully implemented.  ii) Previous audit history or evidence of internal audits completed could not be located on the day of audit. A new internal audit programme introduced 29 July 2016 was not fully implemented to identify actions, follow through and reporting. | i) Ensure that all aspects of the quality and risk management system are implemented.  ii) Ensure that there is a system for storing and retrieving organisational data and information.  60 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Moderate | Clinical indictor data is collected for falls, medication errors, skin tears, bruises pressure injuries, absconding, fractures, soft tissue injury, behaviours, verbal abuse wandering and near miss. This data is collated, however there is no analysis or evaluation of the clinical indicator data and the results are not consistently communicated to the staff or residents. Accident and incident forms have not been completed for all current pressure injuries.  There is evidence that health and safety and hazard management is an agenda item at staff meetings, however the meeting minutes reviewed did not consistently evidence that the results of Health and Safety Audits and the corrective actions required were consistently communicated to staff. | i) The clinical indicator data is collected but not analysed, trended or evaluated.  ii) Health and Safety inspection audits were evidenced, however these audits were not consistently dated or correction actions documented. | i) Ensure that all clinical indicator data is consistently collected, analysed and trended.  ii) Ensure that the results of audits and the corrective actions required are consistently communicated to all staff.  90 days |
| Criterion 1.2.3.7  A process to measure achievement against the quality and risk management plan is implemented. | PA Low | The service has an annual monitoring schedule. The documented audit and monitoring schedule has not been followed since the surveillance audit in May 2016. No completed audits prior to May 2016 could be located during the audit. | Only one of the scheduled audits on the organisation’s scheduled audit planner had been completed since the surveillance audit in May. Other audits have been completed, however not all sections of the audit tool used were consistently completed. | Ensure that the monitoring schedule is fully implemented and all sections of the audit tool are fully completed.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | The service captures quality data. Where areas requiring improvements were noted, corrective action plans were not consistently evidenced. | i) No corrective action plans were sighted or remedial actions evidenced where clinical indicator data, identified areas requiring improvement. For example, areas that were above an acceptable benchmark included falls, bruises and skin tears.  ii) No corrective action plans had been developed and implemented for the deficits noted in the care documentation audits completed in July and September 2016.  iii) Not all corrective action plans that had been documented, were evaluated for effectiveness. | i-iii) Ensure that corrective actions are documented and implemented where areas are identified requiring improvement.  60 days |
| Criterion 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA High | The service has a hazard register in place; however, this has not been reviewed or updated since December 2014. One incident report completed following smoke detector activation noted that the smoke detectors might need replacing. No follow up of this had occurred. The staff report hazards verbally, but no evidence could be found of the use of hazard identification forms. The fire exit corridors were blocked or partially blocked with equipment during the audit. | i) The hazard register had not been reviewed or updated since December 2014.  ii) An incident report dated 23 August 2016 noted the smoke detectors might need replacing. No follow up investigation or action had been taken on the day of audit.  iii) Hazard identification reporting by staff was not evidenced.  iv) An audit is completed using the hazard register bi-monthly however there is no evidence the hazard register is updated if changes are required, and no evidence corrective actions are documented if improvements are needed.  v) Fire exit corridors were partially blocked with equipment and chairs on both days of the audit. On one occasion, a shower trolley was left in the corridor completely blocking the fire exit corridor. | i-iv) Ensure that all aspects of the Health and Safety system are implemented.  v) Ensure that fire exits remain clear at all times.  30 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 Low | The service is required to report pressure injuries on an accident and incident form as part of their quality and management system. Incident and accident forms were not completed for the two current pressure injuries. The facility manager advised the section 31 notification for the stage-three pressure injury was completed on the day of audit. Not all sections of the accident incident forms were consistently completed. | Two of two current pressure injuries had not had an accident and incident form completed.  Not all sections of the accident incident forms were consistently completed. | Ensure that all pressure injuries are reported on an accident and incident form. Ensure incident forms are fully completed.  90 days |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | The staff sign an employment agreement and a job description before they commence work, which outlines the requirements of the role. Not all staff files reviewed could evidence this. | i) One of seven staff files reviewed did not have a signed employment agreement.  ii) Four of seven staff files reviewed did not have a signed job description. | Ensure that all staff have a signed employment agreement and job description on file.  60 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | The service has an orientation programme that is completed by all new staff. Copies of the completed orientation programme were not located in all staff files reviewed. | Four of seven files reviewed did not have evidence of an orientation having been completed. | Ensure that all staff complete the required orientation and that there is a record of this kept on their employment file.  90 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | The registered nurses are responsible for completing the initial InterRAI assessments and reviewing the InterRAI assessments six monthly. Not all initial InterRAI assessments been completed within 21 days of admission and not all InterRAI reassessments were completed six monthly. | i) One recent permanent hospital admission did not have an InterRAI assessment completed within 21 days of admission.  ii) Two of four files reviewed for residents who had been at the service for longer than six months did not have the InterRAI assessments reviewed six monthly. | i) Ensure InterRAI assessments are completed within the required timeframes.  ii) Ensure that all InterRAI assessments are reviewed within the required timeframes.  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 Low | The registered nurse undertakes the InterRAI assessment and any other appropriate assessment to inform the development of the care plan. Not all care plans had been developed on the basis of the information gathered through the InterRAI assessment process. | The long-term care plan for one recent admission was evidenced to have been written before the InterRAI assessment had been completed. | Ensure the InterRAI assessment is completed before the care plan is developed.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA High | The long-term care plans are developed on the basis of the InterRAI and other clinical assessments. Six of six care plans reviewed did not document the support or interventions required to meet the residents assessed care needs and desired goals or outcomes. Care plans were not always documented for acute changes in health condition. | (i) Two residents with pain had no care plan documented for pain management (wound pain and renal calculi).  ii) One resident who had experienced considerable unplanned weight loss prior to admission had no weight management care plan documented.  iii) One resident with a history of hallucinations related to a mental health condition had no management plan documented.  iv) One resident with previous suicidal ideology reported on the resident satisfaction survey they wanted to die. No care plan to manage this risk was documented and no follow-up had occurred. | i-iv) Ensure care plans are documented to reflect the residents’ current needs.  30 days |
| Criterion 1.3.5.3  Service delivery plans demonstrate service integration. | PA Moderate | Integration of nursing, medical and allied health notes were evidenced in resident folders. However, a separate folder in each wing contained a duplicate copy of the residents’ care plan summary, and other care related information for caregivers to read. | A separate folder containing residents care plan summary and other care related information was kept in a folder in each wing for caregivers to read. This duplicate information was not consistently updated when changes to resident’s needs occurred, and no links to this duplicate information were detailed in the resident files.  In the files sampled, the nursing assessment and nursing care plan for a respite resident has not been updated on admission to evidence recent changes to the residents’ needs, identified in recent discharge information from the public hospital. | Ensure that integration of resident information related to care delivery occurs.  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 | There are sufficient dressing supplies and treatment rooms stocked for use. There is a wound folder that identifies which residents have wounds and a management dressing regime. However, comprehensive wound assessments were not evidenced to be completed and wound management plans did not contain sufficient detail to direct the management of the wounds. | i) Two of two residents with pressure injuries (one stage 1 and one stage 3) did not have pressure injury prevention and management strategies fully documented.  ii) Not all interventions in use (applying moisturiser to the skin and use of pressure relieving equipment) were documented for one resident with a stage three pressure injury.  iii) Six of six wounds reviewed did not have a current comprehensive wound assessment documented (including the hospital tracer.)  iv) Six of six wounds reviewed did not have detailed wound management plans including instruction on timeframes for the next review/dressing. | i) Ensure that all wounds have detailed assessments documented, and that wound management plans contain sufficient detail to direct wound management.  ii) Ensure that all interventions in use are documented.  iii) Ensure that there is a comprehensive initial wound assessment and a wound assessment completed with each dressing change.  iv) Ensure that there is a comprehensive wound management plan documented for each wound.  60 days |
| Criterion 1.4.2.1  All buildings, plant, and equipment comply with legislation. | PA Low | The service has a current building warrant of fitness that expires in December 2016. The service has an external contractor come in to test all medical and electrical equipment in use. All medical equipment checked had been tested and calibrated. Not all electrical equipment checked evidenced the equipment had been tested in the required timeframe. | Electrical equipment in use (one battery charger, 4 electric panel heaters and four TVs in resident bedrooms and 2 power cords) had not been tested and tagged in the required timeframes. | Ensure all electrical equipment is tested and tagged in the required timeframes.  60 days |
| Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to: (a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint. | PA High | Restraint and enabler use care plans are documented by the registered nurse and/or the restraint coordinator. Not all residents using a restraint or an enabler had care plans documented to manage the identified risks. Not all monitoring of residents using a restraint was consistently documented. Not all residents had the use of the restraint reviewed following an adverse event. | i) The three restraint care plans reviewed did not document when the restraint was to be initiated or frequency of monitoring required when restraint is in use, and no monitoring of the restraint was evidenced to be occurring.  ii) One resident was observed during the audit using a lap belt when in a wheelchair. An incident form noted the resident had unbuckled the belt and slipped from the chair whilst being restrained two weeks prior to audit. On review of the resident file, a restraint assessment or consent form had not been completed and a care plan had not been documented to manage the risks associated with the use of the restraint. No follow up had occurred of the use of the restraint following this incident. | i) Ensure that all residents using a restraint have the required assessments, consents and care plans documented to manage any identified risks.  ii) Following any adverse event, the use of the restraint is reviewed and any changes that are required are documented on the care plan.  30 days |
| Criterion 2.2.3.5  A restraint register or equivalent process is established to record sufficient information to provide an auditable record of restraint use. | PA Low | A restraint register is maintained by the restraint coordinator and reviewed monthly. Not all residents using a restraint were noted on the register. | One resident was noted on the day of audit to be using a lap belt (restraint) which was not documented on the restraint register. | Ensure the restraint and enabler registers are current.  60 days |
| Criterion 2.2.4.1  Each episode of restraint is evaluated in collaboration with the consumer and shall consider: (a) Future options to avoid the use of restraint; (b) Whether the consumer's service delivery plan (or crisis plan) was followed; (c) Any review or modification required to the consumer's service delivery plan (or crisis plan); (d) Whether the desired outcome was achieved; (e) Whether the restraint was the least restrictive option to achieve the desired outcome; (f) The duration of the restraint episode and whether this was for the least amount of time required; (g) The impact the restraint had on the consumer; (h) Whether appropriate advocacy/support was provided or facilitated; (i) Whether the observations and monitoring were adequate and maintained the safety of the consumer; (j) Whether the service's policies and procedures were followed; (k) Any suggested changes or additions required to the restraint education for service providers. | PA Low | Six monthly evaluation of restraint is completed and monthly individual resident restraint audits have recently been implemented. Not all evaluations on the use of restraint considered the duration of the use of the restraint. | The duration of restraint episodes was not evidenced to be evaluated on six monthly restraint evaluation or monthly individual resident restraint audits reviewed. | Ensure that the duration of restraint episode is evaluated to ensure it is for the least amount of time required.  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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| No data to display |

End of the report.