

Springvale Manor Limited - Springvale Manor Rest Home

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

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| Legal entity: | Springvale Manor Limited |
| Premises audited: | Springvale Manor Rest Home |
| Services audited: | Rest home care (excluding dementia care); Dementia care |
| Dates of audit: | Start date: 22 November 2016 End date: 22 November 2016 |
| Proposed changes to current services (if any): | |

Total beds occupied across all premises included in the audit on the first day of the audit: 22

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

| Indicator | Description | Definition |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

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

General overview of the audit

Springvale Manor Rest Home is privately owned and governed by three directors. The rest home provides rest home level of care for up to eight residents and dementia level of care for up to twenty residents. On the day of the audit there were 22 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

One owner/director is the manager and she is supported by three part-time registered nurses and long-serving staff. The residents and relatives commented positively about the services, care and environment provided at Springvale Manor Rest Home.

Eight of the eleven previous findings relating to family notification of incidents, resuscitation consents, manager education, resident re-assessments, education, admission agreements, interRAI assessments and fridge/freezer temperature monitoring have all been addressed.

Further improvements continue to be required around complaints management, quality data and neurological observations.

This audit also identified one area required for improvement at this audit around interventions.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Some standards applicable to this service partially attained and of low risk. |
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Communication with residents and families is appropriately managed and recorded. There is a documented complaints process.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Some standards applicable to this service partially attained and of low risk. |
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The service continues to implement a quality and risk management programme that includes management of incidents, complaints and infection control data. There is an implemented internal audit programme to monitor outcomes. There is an appropriately experienced owner/manager who provides guidance for the service and is supported by a clinical leader (RN) and experienced home assistants. The clinical leader provides clinical oversight during weekdays and is available after hours. There is an in-service training schedule. The service has sufficient staff allocated to enable the delivery of care.

Continuum of service delivery

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| <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 registered nurses are responsible for the assessments, care plan development and evaluations. The interRAI assessment is being utilised to inform the care plans. Risk assessment tools and monitoring forms are available. Care plans demonstrate service integration. Care plans are evaluated six-monthly or more frequently when clinically indicated. The general practitioner reviews the residents at least three-monthly.

A diversional therapist and activity assistant provide an activity programme for both areas (rest home and dementia care) to meet the needs of both groups of residents. Home assistants are involved in implementing the programme in the dementia care unit. Each resident has an individualised plan. Residents are encouraged to participate in community activities. There are regular drives and outings for all residents.

The medication management system follows recognised standards and guidelines for safe medicine management practice. Staff responsible for administering medications complete annual competency assessments.

Meals are prepared in the kitchen by qualified cooks. Individual and special dietary needs and dislikes are accommodated. There are nutritious snacks available at all times. Residents interviewed responded favourably about the food that was provided.

Safe and appropriate environment

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

Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. | | Standards applicable to this service fully attained. |
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The service has policies and procedures that meet the definitions of enablers and safe use of restraint. There were no residents using enablers and one resident with a restraint in place. A registered nurse is the restraint coordinator. Staff receive annual training around restraint, challenging behaviours and de-escalation techniques.

Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. | | Standards applicable to this service fully attained. |
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for collating infection control data and communicating information to the management and staff. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|--------------------------|------------------------------------|----------------------------|---|---|---|---|---|
| Standards | 0 | 15 | 0 | 3 | 1 | 0 | 0 |
| Criteria | 0 | 38 | 0 | 3 | 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 |
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| <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>Resuscitation forms reviewed in five of five resident files had been signed appropriately. The general practitioner (GP) has recorded a medically indicated resuscitation status where they had deemed the resident incompetent to make a decision. There is documented evidence the GP has discussed the resuscitation status with the enduring power of attorney (EPOA). The previous finding around the appropriate signing of resuscitation consents has been addressed. Advance directives where available were kept in the resident's file. Copies of the EPOA and letter of mental capacity as appropriate were in the residents file.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p> | PA Low | <p>The service has a complaints policy that describes the management of the complaints process. The owner/manager is responsible for complaint investigations and advised that she responds to complaints. There has been one complaint made since the last audit. The reviewed complaint had no documented evidence of corrective actions and resolution. A complaint register has not been maintained. Complaint forms are available at the entrance of the service. Information about complaints is provided on admission. Care staff interviewed were able to describe the process around reporting complaints. Residents and family members interviewed stated that they are aware of</p> |

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| understood, respected, and upheld. | | the complaints procedure and how to access forms. |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>The owner/manager or the clinical leader (RN) welcomes residents and families on entry and explains about services and procedures. Five residents interviewed confirmed the admission process and agreement was discussed with them and they were provided with adequate information on entry. There is an open disclosure policy in place, information on which is included at the time of admission. Incident and accident forms are completed by home assistants and other staff members, clinical follow-up is completed by the RN and signed off by the owner/manager. Nineteen incident forms reviewed for October and November 2016 identified family were notified following a resident incident. The finding from the previous audit is now met. Two relatives (dementia level) interviewed stated that they were informed when their family member's health status changed.</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> | FA | <p>Springvale Manor Limited is the proprietor of Springvale Manor. Three directors, including the wife and husband owner/operators are the governing body for Springvale Manor Limited. The directors meet three-monthly. The manager/owner is able to describe the company's financial and business goals. The company vision statement is visible on the wall at the front entrance and in the information brochures that are readily available. There is a 2016 business plan that outlines objectives for the period; a particular focus being increasing occupancy.</p> <p>Springvale Manor provides rest home and dementia level care for up to 28 residents (eight rest home and twenty dementia beds). On the day of audit, there were five rest home residents and seventeen residents in the secure dementia unit.</p> <p>The owner/manager (non-clinical) works full-time and has been in the position for seven and a half years. She is supported by a clinical leader (RN) and two other part-time RNs who works 32 hours per week each on mornings, afternoons and nights as per the roster. The clinical leader maintains a competent level of professional recognition and development programme.</p> <p>The manager/owner has maintained at least eight hours annually of professional development activities related to managing a rest home. She completed a full day Careerforce advanced assessor workshop course in September 2015. The finding from the previous audit is now met.</p> |
| <p>Standard 1.2.3: Quality And Risk Management</p> | PA Low | <p>The quality manual and the business, quality and risk management planning describe Springvale Manor's quality improvement processes. Policies and procedures are developed by an external consultant and the manuals are updated when policies have been reviewed. Springvale Manor continues to implement an internal audit programme that includes clinical and non-clinical aspects of the services. Issues arising from internal audits are documented as</p> |

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| <p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | | <p>corrective actions. Review of documents and staff interviews confirmed this. Discussions with the RNs, diversional therapist and home assistants confirmed their involvement in implementation of the quality programme. Resident and relatives survey was completed in May 2016 and shows satisfaction with services provided.</p> <p>Springvale Manor has a health and safety management system. There are implemented risk management, health and safety policies and procedures including accident and hazard management. Monthly accident/incident reports and infection control surveillance data were completed. The service communicates relevant information to staff, however, review of meeting minutes showed lack of details around discussion of the quality data and corrective actions.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>PA Low</p> | <p>Springvale Manor documents and analyses incidents/accidents, unplanned or untoward events. A sample of 19 incident reports for October and November 2016 were reviewed. Incident and accidents were reported to the RN and the owner/manager for action if required. However, neurological observations had not been completed for unwitnessed falls where the resident potentially hit their head. Incidents/accident forms were all signed off by the RN or the owner/manager. Staff interviews (two home assistants, the RN and the diversional therapist) confirmed active involvement in management of risks. Discussion with the owner/manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. The service initiate re-assessments for residents requiring a higher level of care. Two rest home residents have had interRAI assessments completed due to changes in health. The needs assessment team have been notified. The previous finding around referrals for re-assessments has been addressed.</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</p> | <p>FA</p> | <p>Human resources management policies are implemented. Professional qualifications are validated as part of the employment process. Copies of professional practising certificates are held on-site for the RN, the GP and the pharmacist. Six staff files were reviewed (one clinical leader, one RN, one cook and three home assistants). All files had employment records, completed orientation and annual performance appraisals.</p> <p>Staff receive an orientation and on-site support with a senior staff member. There is an orientation programme that provides new staff with relevant information for safe work practice. The clinical leader maintains competent level of the professional development recognition programme. The clinical leader confirmed access to external training and online training. The RNs have all completed interRAI training.</p> <p>A two-yearly education plan is implemented covering all the relevant requirements and attendance records are</p> |

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| requirements of legislation. | | maintained. Staff complete competencies following in-service sessions. Thirteen of thirteen home assistant have completed the required dementia standards. The cook completed the food safety certificate unit 167 in March 2016. The finding from the previous audit is now met. Eight hours of staff development or in-service education has been provided annually. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides coverage across both areas. Staffing cover is appropriate to the layout of the facility and the scope of the service delivery. Two home assistants and three RNs interviewed confirm they have appropriate staffing numbers and skill mix on their shifts. Family interviews confirmed adequate staffing. The owner/manager describes low staff turnover. There are three staff members on duty on each shift including weekends. The RN's each work 32 hours per week. A qualified diversional therapist works 40 hours per week. The owner/manager works full-time. Both the owner/manager and clinical leader/RN are on call after hours. |
| 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' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families and residents prior to admission. Five admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement. The previous finding around admission agreements have been addressed. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative | FA | There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses and senior home assistants administer medications and have completed annual medication competencies. Medication education had been provided in preparation for the installation of an electronic medication system. The service uses four-weekly blister packs which are checked against the medication signing sheet by the RN. All medications are stored safely. There were no self-medicating residents on the day of audit. Standing orders are not used. Ten medication charts were reviewed. All medication charts had photo identification and allergy status documented. Prescribing of regular and 'as required' medication met legislative requirements. All medication charts had been |

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| requirements and safe practice guidelines. | | reviewed by the GP at least three-monthly. Administration signing sheets corresponded with the medication chart. |
| <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>All meals and home baking is prepared and cooked on-site. The qualified cook on duty is supported by a morning kitchenhand and tea aide. Food services staff have completed food safety hygiene training. There is a four-weekly menu that has been reviewed by a dietitian. The chef receives resident dietary instructions that includes resident dislikes and special requirements. Dislikes are accommodated. The cook is notified of any changes to resident's dietary needs or residents with any weight loss. The kitchen is adjacent to the dementia care dining room. Meals are delivered to the separate rest home dining room. Nutritious snacks are available at all times</p> <p>Kitchen fridges and freezer temperatures are monitored daily and recorded. The previous finding around fridge and freezer temperature monitoring has been addressed. End cooked food temperatures are monitored and recorded daily.</p> <p>Rest home residents interviewed commented positively on the meals provided.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>Residents' long-term care plans reviewed were resident-focused and individualised. InterRAI assessments are utilised and inform the long-term care plan. The previous finding around interRAI assessments has been addressed. The long-term care plans reviewed documented the required supports/needs to meet the resident goals. Relatives interviewed confirmed they were involved in the care planning process. Long-term care plans evidenced resident (as appropriate) and/or relative involvement in the development of care plans.</p> <p>Short-term care plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan.</p> |
| <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>Documentation reviewed and interviews with staff, residents and relative identified that care is being provided consistent with the needs of residents. When a resident's condition changes, the RN initiates a GP referral. There was evidence in the progress notes and on the accident/incident forms that families were notified of any changes to their relative's health including (but not limited to): accidents/incidents, infections, health professional visits and changes in medications. Not all interventions had been documented or implemented.</p> <p>Dressing supplies were sighted and are readily available for use. Wound management policies and procedures are in place. Wound assessments and ongoing wound evaluations describe the treatment, frequency of change of dressings and evaluations of wounds. There were four residents with wounds (one surgical, two superficial wounds and one pressure injury). The stage I pressure injury of the heels was hospital acquired. Not all wounds had wound management documentation in place. The RN interviewed described the process should they require assistance</p> |

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| | | <p>from a wound specialist.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.</p> <p>Monitoring forms are used to record a resident's progress towards meeting short-term supports for changes in health.</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> | FA | <p>The service employs a qualified diversional therapist (DT) Monday to Friday from 8am to 4pm. She is supported by an activity assistant three days a week from 10am to 6pm. The activity team provide a varied programme that is flexible to meet the needs of the dementia care residents and the rest home residents. Consent is gained from rest home residents and their families to join some activities in the dementia unit such as entertainment and church services. The DT has allocated time to spend with rest home residents including one-on-one time.</p> <p>Activities offered include crafts, nail care, baking for the ladies group, happy hours, reminiscing, sing-a-longs and walks.</p> <p>A van is hired for regular outings/drives into the community and attending social events.</p> <p>Home assistants are involved in providing activities a part of their role. A sensory room in the dementia unit provides a low stimulus environment with soothing music and low lighting which reduces resident agitation and decreases episodes of challenging behaviours.</p> <p>Residents and relatives provide feedback on the activity programme through verbal feedback and six-monthly multidisciplinary meetings.</p> <p>Activity assessments are completed soon after admission. Each resident had an individual activity plan which is reviewed six-monthly.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Two long-term care plans reviewed had been evaluated six-monthly by a registered nurse. Written evaluations have been completed and demonstrate relative/resident involvement in the care plan review. There was documented evidence of care plans being evaluated against the resident's goals as being met or unmet. InterRAI assessments have been completed six-monthly as part of the care plan review. Two residents (one rest home and one dementia care) had not been at the service long enough for a six-monthly evaluation. The resident under intermediate care contract was not required to have a long-term care plan. There is at least a three-monthly review by the medical practitioner.</p> |

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| <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 that expires on 22 June 2017.</p> |
| <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> | <p>FA</p> | <p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (RN) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Monthly infection control reports are provided. The monthly infection control data report including trends, analysis and corrective actions is displayed on the staff noticeboard. Definitions of infections are in place appropriate to the complexity of service provided. Internal audits for infection control are included in the annual audit schedule. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there were no residents with enablers and one resident with a restraint (lap belt). The restraint coordinator is a registered nurse. Challenging behaviour and de-escalation education is included in the training programme.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
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| <p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p> | PA Low | <p>The service has a complaints policy that describes the management of the complaints process. The owner/manager is responsible for complaint investigation. Care staff interviewed were able to describe the process around reporting complaints. The one complaint reviewed for 2016 did not include follow up and outcome. The complaint register has not been maintained.</p> | <p>A complaint was received September 2016. There was no documented evidence of corrective actions and resolution for the complaint. There was no documented complaint register in place.</p> | <p>Ensure that there is a documented complaint register in place. Ensure complaints include documented follow up and resolution.</p> <p>90 days</p> |

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| <p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | <p>PA Low</p> | <p>Quality data related to incident and accidents, infection control, hazard management, environmental safety, restraint minimisation, complaints and training and audit outcomes are collected. The staff meeting template includes headings relating to these items, however meeting minutes do not reflect that these have been routinely discussed and communicated to staff.</p> | <p>There was no documented evidence that meeting minutes included discussion around quality data trends analysis and what actions were required by staff. There was no evidence of internal audit outcomes being discussed at staff meetings.</p> | <p>Ensure that staff meeting minutes include discussion of quality data trends analysis and actions required, if any. Ensure that internal audit outcomes are discussed at staff meetings.</p> <p>90 days</p> |
| <p>Criterion 1.2.4.3</p> <p>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.</p> | <p>PA Low</p> | <p>Incident forms are completed by care staff, the resident is reviewed by the registered nurse at the time of event if she is on-site and is notified by home assistants if incidents occur after hours. Family are notified by the registered nurse. Nineteen incident forms were reviewed across October and November 2016. Neurological observations had not been completed for unwitnessed falls.</p> | <p>Nineteen incident forms were reviewed for October and November 2016. There were four forms reviewed of residents who had unwitnessed falls in the dementia unit. There were no records of neurological observations completed or documented for these residents.</p> | <p>Ensure that neurological observations are documented and completed for any unwitnessed falls where staff cannot confirm the resident has not hit their head.</p> |

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| | | | | 90 days |
| <p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p> | <p>PA</p> <p>Moderate</p> | <p>The use of monitoring charts such as observations, weights, behaviour, blood sugar levels and wound evaluations document progress towards meeting short-term goals. Short-term care plans are available for the documenting of changes and supports required for any changes to the resident's health status. A shortfall was identified around interventions.</p> | <p>(i) There were no wound assessments for one resident with an open wound of the toes and one resident with a stage I pressure injury of heels. The change of dressing for one other wound had not been documented as completed as per the documented frequency, (ii) There were no documented interventions for one dementia care resident for a) changes to mobility and b) risks associated with the use of a restraint (lap belt). The same resident did not have recent episodes of challenging behaviour documented on the behaviour chart, (iii) There were no documented interventions for another dementia care resident at risk of absconding and (iv) the effectiveness of 'as required' pain relief had not been documented for one resident on an intermediate care contract (link rest home tracer 1.3.3.)</p> | <p>(i) Ensure wound assessments and evaluations are completed; (ii)- (iii) Ensure interventions are documented to meet the resident's current health status. (iv) Ensure pain relief is evaluated</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.