

Selwyn Care Limited - Gracedale Hospital

Introduction

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

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

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

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

The specifics of this audit included:

| | |
|---|--|
| Legal entity: | Selwyn Care Limited |
| Premises audited: | Gracedale Hospital |
| Services audited: | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 1 February 2017 End date: 2 February 2017 |
| 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: | 36 |

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Gracedale is owned by a Trust and operated by the Selwyn Foundation. The service cares for up to 36 residents requiring rest home or hospital level care. On the day of the audit the facility was full. All residents were under the Age Related Care Contract.

The service is managed by a facility manager, who is a registered nurse with clinical management and aged care experience. She is supported by a clinical coordinator (the role was vacant on audit day), registered nurses and the group residential care manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

Improvements are required around the assessment and management of pressure injuries and weight loss, integration of resident files, updating care plans when needs change and one aspect of medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.



Standards applicable to this service fully attained.

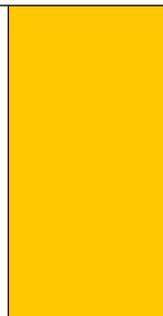
Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receives ongoing training about the Code.

The personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families, are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Data is collected, analysed, discussed and changes made as a result of trend analysis. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

| | | |
|---|--|---|
| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
|---|--|---|

The facility manager takes primary responsibility for managing entry to the service with assistance from the registered nurses. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including InterRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the InterRAI outcomes and other assessments.

Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

There are medication policies in place that comply with current legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed.

Meals are prepared on site by a contracted agency under the direction of a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. Ongoing and reactive maintenance issues are addressed. Chemicals are stored safely throughout the facility. There is sufficient space to allow the movement of residents around the facility using mobility aids. Each resident wing has its own combined dining and lounge area. The internal areas are able to be ventilated and heated. The outdoor areas are safe and easily accessible. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

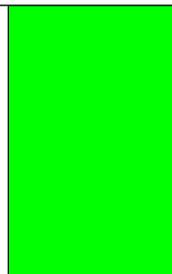


Standards applicable to this service fully attained.

Staff regularly receives training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. A register is maintained by the restraint coordinator. Two residents were using restraints and two residents were using enablers.

Infection prevention and control

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



Standards applicable to this service fully attained.

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 also 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. There have been no outbreaks since the previous audit.

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 | 46 | 0 | 2 | 2 | 0 | 0 |
| Criteria | 0 | 97 | 0 | 2 | 2 | 0 | 0 |

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

Attainment against the Health and Disability Services Standards

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

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

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

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

| Standard with desired outcome | Attainment Rating | Audit Evidence |
|---|-------------------|--|
| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Gracedale policies and procedures are being implemented that align with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Families and residents are provided with information on admission which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with care staff (six caregivers, three registered nurses and one activities coordinator) confirmed their understanding of the Code. Seven residents (four rest home level and three hospital level) and four relatives (three hospital level and one rest home level) interviewed, confirmed that staff respect privacy and support residents in making choices.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | FA | <p>The service has policies and procedures relating to informed consent and advanced directives. All six resident files reviewed included signed informed consent forms and advanced directive instructions. Staff are aware of advanced directives. Admission agreements were sighted, which were signed by the resident or nominated representative. Discussion with residents and families identified that the service actively involves them in decision making.</p> |

| | | |
|--|-----------|--|
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | <p>FA</p> | <p>Residents interviewed confirmed they are aware of their right to access independent advocacy services. Discussions with relatives confirmed the service provided opportunities for the family/EPOA to be involved in decisions. The chaplain is identified by staff and residents as an advocate. The resident files include information on resident's family/whānau and chosen social networks.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | <p>FA</p> | <p>Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community. Relatives and friends are encouraged to be involved with the service and care.</p> |
| <p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>FA</p> | <p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register that includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in management and staff meetings. All complaints received have been documented as resolved with appropriate corrective actions implemented.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>There is an information pack given to prospective residents and families that includes information about the Code and the nationwide advocacy service. There is the opportunity to discuss aspects of the Code during the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Large print posters of the Code and advocacy information are displayed throughout the facility. A manager discusses the information pack with residents/relatives on admission. Families and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p> |

| | | |
|--|-----------|--|
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>A tour of the premises confirmed there were areas that support personal privacy for residents. Staff were observed to be respectful of residents' privacy by knocking on doors prior to entering resident rooms. Staff could describe definitions around abuse and neglect that aligned with policy. Residents and relatives interviewed confirmed that staff treat residents with respect.</p> <p>The service philosophy promotes quality of life and involves residents in decisions about their care. Resident preferences are identified during the admission and care planning process and include family involvement. Interviews with residents confirmed their values and beliefs were considered. Caregivers could describe how choice is incorporated into resident cares.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>Selwyn has established a spiritual and cultural advisory group. This group includes the Foundation's Pou Tikanga who provides guidance and input on Māori culture and practices.</p> <p>The Selwyn Way policy incorporates the principles of the Treaty of Waitangi, and procedures are in place for adhering to Māori cultural practices where appropriate.</p> <p>Family/whānau involvement is encouraged in assessment and care planning and visiting is encouraged. Links are established with disability and other community representative groups as requested by the resident/family. Cultural needs are addressed in the care plan. Residents who identified as Māori confirmed their cultural needs were being met by the service.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | <p>FA</p> | <p>An initial care planning meeting is carried out where the resident and/or whānau as appropriate are invited to be involved. Individual beliefs or values are discussed and incorporated into the care plan. Six monthly multidisciplinary team meetings occur to assess if needs are being met. Family are invited to attend. Discussions with relatives confirmed that residents' values and beliefs are considered. Residents interviewed, confirmed that staff take into account their values and beliefs.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers (one facility manager, one clinical quality manager and one group residential care manager) and care staff confirmed their awareness of professional boundaries.</p> |

| | | |
|---|-----------|--|
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>Policies and procedures are aligned with current accepted best practice. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff.</p> <p>An annual in-service training programme is implemented as per the training plan. Registered nurses are able to attend DHB training and caregivers are provided with a training programme. The service benchmarks with other Selwyn Foundation services and uses outcomes to improve resident outcomes. Feedback is provided to staff via the staff/quality meetings.</p> <p>There is a minimum of one registered nurse on each shift. Residents and family advised that caregivers are caring and competent.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | <p>FA</p> | <p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. The sample of adverse events reviewed met this requirement. Family members interviewed confirmed they are notified following a change of health status of their family member. The service has exceeded the standard around ensuring that all staff are able to communicate effectively with residents.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p> | <p>FA</p> | <p>Gracedale is owned by a Trust and operated by the Selwyn Foundation. The facility is certified to provide rest home and hospital (geriatric and medical) level care for up to 36 residents. All rooms are dual-purpose and on audit day the service was at full capacity with seven rest home level residents and twenty-nine hospital level residents. There were no residents on the medical component and all residents were on the Aged Related Care contract.</p> <p>The organisational strategic plan 2013 to 2017 documents organisational goals. These are reflected in the 2016 Gracedale business plan, which describes the vision, values and objectives of Gracedale and has been ratified by the board. Goals for 2016 have been reviewed and the board was in the process of signing off the 2017 goals. Annual goals are linked to the business plan and reflect regular reviews via facility meetings.</p> <p>The facility manager is a registered nurse and has aged care experience. She has worked at Gracedale since the service opened in a variety of roles and is supported by a clinical coordinator and the group residential care manager. The clinical coordinator position was vacant and being recruited for at the time of the audit and the organisations clinical quality manager, who has previously been clinical coordinator at Gracedale is providing clinical support.</p> |

| | | |
|---|----|---|
| | | <p>The facility manager reports monthly to the board and provides a formal monthly report and has ongoing contact and liaison with the group residential care manager for Selwyn.</p> <p>The facility manager has maintained at least eight hours of professional development activities related to managing an aged care facility.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>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.</p> | FA | <p>The clinical coordinator or a senior registered nurse covers during the temporary absence of the facility manager with support from the residential group care manager.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA | <p>An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the group residential care manager. Discussions with the managers, the GP, and staff reflected staff involvement in quality and risk management processes.</p> <p>Resident meetings are monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results reflect high levels of satisfaction.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the clinical governance group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to policies included procedures around the implementation of InterRAI.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data. This is utilised for service improvements. Key performance areas are benchmarked against other Selwyn facilities. Quality improvement plans (QIPs) are developed when service shortfalls are identified and these are monitored by group office. Results are communicated to staff at staff meetings and reflect actions being implemented and signed off when completed.</p> |

| | | |
|--|----|---|
| | | <p>Health and safety policies are implemented and monitored by the health and safety committee. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including (but not limited to) sensor mats, increased monitoring, identification and meeting of individual needs and mattress perimeter guards.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of 14 incident/accident forms (a sample from January 2017) identified that forms are fully completed and include follow-up by a registered nurse. Neurological observations are completed for any suspected injury to the head. The clinical coordinator (when the position is filled) and facility manager are involved in the adverse event process.</p> <p>The group residential care manager was able to identify situations that would be reported to statutory authorities including (but not limited to) infectious diseases, serious accidents and unexpected death. Section 31 notifications have been made around fractures and pressure injuries and an incident regarding a visitor. A potential norovirus outbreak was reported but then determined not to be an outbreak.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (two registered nurses, a cleaner/laundry staff member, the activities coordinator and two caregivers) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals.</p> <p>Registered nursing staff and other health practitioner practising certificates are maintained on file.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. The training plan is implemented using a 'train the trainer' model where key staff are trained to provide education sessions on subjects that cover a number of required trainings. Aspects of training are provided during full day training sessions. Incidental training is provided according to identified need</p> |

| | | |
|---|----------------|--|
| | | <p>and at staff request. There is an attendance register for each training session and an individual staff member record of training.</p> <p>Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p> | FA | <p>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is at least one registered nurse on duty at all times. A registered nurse from the management team is on call at all times. Activities are provided five days a week.</p> <p>Staff were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | PA Moderate | <p>Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. 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. Entries are legible, dated and signed by the relevant caregiver or nurse including designation. Individual resident files were not integrated.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. Six signed admission agreements were sighted. The admission agreement form in use aligns with contractual requirements.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p> | FA | <p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and 'the yellow envelope' is used. The RNs report that they include copies of all the required information in the envelope.</p> |

| | | |
|---|--------|---|
| discharge, or transfer from services. | | |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | PA Low | <p>Twelve medication charts were reviewed (four rest home and eight hospital). There are policies available for safe medicine management that meet legislative requirements. The service has recently introduced an electronic medication management system. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident at least three monthly.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Not all medication was stored correctly. Registered nurses interviewed could describe their role regarding medication administration. Administration records demonstrated that medications were administered as prescribed. The service currently uses a robotic roll system for regular medications and blister packs for 'as required' medication. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>Standing orders are in use and contraindications for each medication are documented. There were two residents self-medicating on the day of audit. The residents self-medicating had completed the necessary documentation and competency assessments.</p> <p>The medication fridge temperature is recorded regularly and is within the acceptable ranges.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | FA | <p>All meals at Gracedale are prepared and cooked on site by an external contractor. There is a six-weekly seasonal menu, which was reviewed by a dietitian in April 2016. Food is transported to the four resident dining areas via a bain-marie. The temperature of the food is checked before leaving the kitchen. The kitchen staff were not aware of all resident's special dietary requirements on the day of audit (link 1.3.6.1). Individual resident likes and dislikes are accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were very complimentary about the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. The dishwasher is checked regularly by the chemical supplier. Fridge temperatures are recorded for the fridges in each resident dining/servery area.</p> |

| | | |
|--|----------------|---|
| | | All food services staff have completed training in food safety and hygiene and chemical safety. |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | The reason for declining service entry to prospective residents to the service is recorded. Should this occur, the manager stated it would be communicated to the potential resident/family/whānau and the appropriate referrer. Potential residents would only be declined if there were no beds available or if they could not meet the service requirements. |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained appropriate assessment tools that were completed and assessments that were reviewed at least six monthly or when there was a change to a resident's health condition. The InterRAI assessment tool is implemented. One of the five registered nurses are InterRAI trained. InterRAI assessments have been completed for all residents. Care plans sampled were developed on the basis of these assessments. |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | The care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings (link 1.3.6.1). The service has a number of care plans in use (eg, nursing care plan, lifestyle plan, short-term care plan, and wound care plan). The care plans reviewed were resident focused however the information documented in the care planning documents was not always consistent (link 1.2.9.10). The InterRAI assessment process informs the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Short-term care plans are in use for changes in health status. |
| <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</p> | PA Moderate | A written record of each resident's progress is documented. Resident changes in condition are followed-up by a registered nurse as evidenced in residents' progress notes. When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. |

| | | |
|---|-----------|---|
| <p>outcomes.</p> | | <p>In the files reviewed short-term care plans were evidenced following a change in health condition and linked to the nursing care plan documents (link 1.2.9.10). Long-term nursing care plans were reviewed six monthly.</p> <p>There was evidence in the files sampled of referral for specialist advice. Not all action plans documented by the dietitian in the progress notes had been implemented or documented in the nursing care plans.</p> <p>Dressing supplies are available. Wound care documentation was reviewed for nine hospital residents with skin tears and one rest home resident with a blister (tracer). Wound care plans and short-term care plans were completed for seven of ten wound care plans reviewed (six hospital and one rest home) and there was evidence of wound care specialist nurse and GP involvement in the management of these wounds. Not all wound care documentation was fully completed.</p> <p>There were three hospital residents with six facility acquired pressure injuries on the day of audit (one resident (tracer) with three pressure injuries - one stage-two, one stage-three and one stage-four, one resident with a stage-three resolving to stage-two pressure injury and two hospital residents with stage-two pressure injuries). There has been GP involvement in the management of the pressure injuries but no wound care specialist nurse involvement.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses could describe access continence specialist input as required.</p> <p>Monitoring forms are in use by the registered nurses. Forms sighted included monthly blood pressure and weights, pain monitoring, nutritional and food monitoring and behaviour monitoring and turning charts.</p> |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The activity programme confirmed that independence was encouraged and choices were offered to residents. The activity coordinator works 30 hours per week and is supported by four volunteers. Volunteers primarily undertake one-to-one interventions. A wide range of activities addressing the abilities and needs of different residents are offered. The programme has a strong focus on individuality and independence. The activities coordinator has utilised the resident groups' interest in reminiscing and most activities relate in some way back to residents past experiences. For example, the Fruity Friday involves seeing, tasting and smelling, and then tasting a fruit that may be less commonly known to the residents. They are then encouraged to talk about a previous experience with the fruit, a recipe they or their family used using it, or a holiday where they saw or tasted this fruit or something similar.</p> <p>Activities included physical, mental, spiritual and social aspects of life to improve and maintain</p> |

| | | |
|---|--------|--|
| | | <p>residents' wellbeing.</p> <p>On admission, an activity coordinator completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident's activities and progress notes are completed monthly. Reviews are conducted six monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.</p> <p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement. A library bus calls and the service owns a van. The activities coordinator has current first aid certificates.</p> <p>A resident meeting is held monthly where residents and relatives have input. Minutes are recorded at the meeting, quality improvements identified and feedback given.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | PA Low | <p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan was evaluated at least six monthly or earlier if there is a change in health status. The interventions and evaluations are documented in the same section of the nursing care plan with the evaluations written in narrative form below the interventions section. Not all interventions are updated with a change in health condition. There was at least a three monthly review by the GP. In the resident files sampled reassessments have been completed at least six monthly using the InterRAI LTCF tool, and where a resident has had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled (link 1.2.9.10).</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | FA | <p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Residents and/or their family/whānau are involved as appropriate when a referral to another service occurs. Registered nurses interviewed described the referral process should they require assistance.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> | FA | <p>The service has documented policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. Waste is appropriately managed.</p> |

| | | |
|---|-----------|--|
| <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | | <p>Chemicals were secured in designated locked cupboards. Chemicals were labelled and safety datasheets were available throughout the facility and accessible to staff. Safe chemical handling training has been provided. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>The building has a current building warrant of fitness which expires on 30 March 2017. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | <p>FA</p> | <p>Thirty-four resident rooms have full ensuite bathrooms and two resident rooms share an ensuite. The ensuites and communal toilet facilities have privacy locks. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | <p>FA</p> | <p>All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</p> |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe,</p> | <p>FA</p> | <p>Each of the four wings have their own dining/lounge area and kitchenette which can be easily and safely accessed by the residents. Furniture is appropriate to the setting and arranged in a manner, which enables residents to mobilise freely. There is a large accessible lounge, which is used, for activities and a specific area for the hairdresser. The outdoor courtyards are also used for activities.</p> |

| | | |
|--|----|---|
| adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | | |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | FA | <p>Dedicated cleaning staff are rostered on 7 days per week. They have access to a range of chemicals, cleaning equipment and protective clothing. The standard of cleanliness is monitored through the internal audit programme.</p> <p>The laundry is all completed on site and dedicated laundry staff are rostered on 7 days per week. Laundry and cleaning staff interviewed advised that they had received training in chemical safety, infection control and waste management.</p> <p>Cleaning products and laundry products are well labelled and kept in securely locked cupboards and chemical safety data guidelines are available.</p> <p>The laundry and cleaning service has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Residents interviewed were satisfied with the standard of cleanliness in the facility and the laundry service.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | FA | <p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service provides checking of all facility equipment including fire equipment. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place. There are sufficient first aid and dressing supplies available.</p> <p>All registered nurses have current first aid certificates and at least one registered nurse is available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity on the day of audit.</p> <p>Appropriate security systems are in place including CCTV cameras.</p> |
| Standard 1.4.8: Natural Light, Ventilation, And Heating | FA | Residents are provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. |

| | | |
|--|-----------|---|
| <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | | |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | <p>FA</p> | <p>Gracedale 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 and the Selwyn KPIs. A registered nurse is the designated infection control nurse with support from the clinical coordinator. The quality meeting team is the infection control team. Minutes are available for staff. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The Selwyn Foundation infection control programme was last reviewed in December 2016.</p> |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | <p>FA</p> | <p>A registered nurse at Gracedale is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team (comprising all staff) has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. The infection control team is representative of the facility. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of</p> | <p>FA</p> | <p>There are Selwyn Foundation 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 were developed by the Selwyn clinical governance and have been reviewed and updated.</p> |

| | | |
|--|----|---|
| service provided. | | |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education has occurred for staff. The infection control nurse has completed infection control training through the Selwyn infection control coordinators bi-annual meeting/training days. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Infection surveillance is an integral part of the infection control programme and is described in Selwyn's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible. There have been no outbreaks since the previous audit. The DHB and Public Health were informed as a precaution of a potential outbreak but no outbreak resulted.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>Restraint practices are only used where it is clinically indicated and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>There were two residents using enablers and two hospital residents with three restraints (two bedrails and one brief restraint). Restraint use is voluntary.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of</p> | FA | <p>The restraint approval process is described in the restraint minimisation policy. Roles and responsibilities of the restraint coordinator (a registered nurse) and for staff are documented and understood. The restraint approval process identifies the indications for restraint use, consent process, duration of restraint and monitoring requirements.</p> |

| | | |
|---|----|---|
| 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. | | |
| Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | <p>A restraint assessment tool is completed for residents requiring an approved restraint for safety. Assessments are undertaken by the restraint coordinator in partnership with the RNs, GP, resident and their family/whānau. Restraint assessments are based on information in the care plan, resident/family discussions and observations.</p> <p>Ongoing consultation with the resident and family/whānau are evident. The two residents' files where restraint was in use were selected for review. The completed assessment considered those listed in 2.2.2.1 (a) - (h).</p> |
| Standard 2.2.3: Safe Restraint Use Services use restraint safely | FA | <p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint.</p> <p>The use of restraint is linked to the residents' care plans. Internal restraint audits measure staff compliance in following restraint procedures. Each episode of restraint is monitored at pre-determined intervals depending on individual risk to that resident. Monitoring is documented on a specific restraint monitoring form, evidenced in the two resident files where restraint was being used.</p> <p>A restraint register is in place providing an auditable record of restraint use and is completed for all residents requiring restraints and enablers.</p> |
| Standard 2.2.4: Evaluation Services evaluate all episodes of restraint. | FA | <p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are conducted monthly and restraint use is discussed monthly at both registered nurse and staff meetings. A review of two resident files identified that evaluations were up-to-date.</p> |
| Standard 2.2.5: Restraint Monitoring and Quality Review | FA | <p>The restraint minimisation programme is discussed and reviewed at the six monthly organisation-wide restraint coordinators meetings, monthly registered nurse meetings and monthly staff meetings.</p> |

| | | |
|---|--|--|
| Services demonstrate the monitoring and quality review of their use of restraint. | | Meeting minutes include (but are not limited to) a review of the residents using restraints or enablers, updates (if any) to the restraint programme and staff education and training. |
|---|--|--|

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|---|---------------------------|--|--|--|
| <p>Criterion 1.2.9.10</p> <p>All records pertaining to individual consumer service delivery are integrated.</p> | <p>PA</p> <p>Moderate</p> | <p>All residents have a file that contains relevant information about the resident. However several other documents pertaining to each resident are kept in various folders and areas and information is not consistent between the different documents.</p> | <p>There are a number of folders in use in the clinical area containing resident information - (resident file, wound folder, short-term care plans, care givers information, daily care chart, bowel book and other monitoring records). The resident information is not integrated and the information documented in each folder/area is not consistent.</p> <p>One resident (hospital tracer) with three PIs had interventions documented to</p> | <p>Ensure resident files are integrated.</p> <p>60 days</p> |

| | | | | |
|--|--------|---|---|--|
| | | | manage the PIs in multiple areas including the progress notes, wound care plan, short-term care plan, nursing care plan, lifestyle care plan and in the evaluation comments of the long-term nursing care plan. The interventions to manage the PIs was not updated in all areas wound management was documented and the interventions noted were not consistent between documents. | |
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | PA Low | The service has documented policies and procedures to guide staff in all areas of safe medication management practices. Medication is prescribed and dispensed correctly and staff complete the required medication checks. On the day of audit a resident was being given 5mgs of morphine that was being drawn from a 10mg vial. The unused part portion of the morphine vial was found secured in the locked drug cupboard. The opened vial was covered with micropore tape. The registered nurses interviewed advised that they were only using half a vial with each dose and this vial was being retained for use later that day. | A part vial of morphine was found opened and covered with micropore tape in the controlled drug cupboard. This vial was being retained for later use. | <p>Ensure that the storage and disposal of medication complies with all legislative and contractual requirements.</p> <p>30 days</p> |

| | | | | |
|---|------------------------|--|---|--|
| <p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p> | <p>PA Moderate</p> | <p>The registered nurses develop the care plans based on the InterRAI and other nursing assessments. Where external support is required referrals are made to allied health care professionals. In the files reviewed there was evidence of specialist support being accessed (speech and language therapists, mental health services, physiotherapist dietitian, podiatrist and wound care specialist nurse). Not all interventions noted in the progress notes by the dietitian were transferred to the care plan or implemented for residents with weight loss.</p> <p>Wounds are assessed by the registered nurse and a short-term care plan, and a wound care plan documented. Not all wounds had the initial assessments and ongoing assessments fully documented. One resident (hospital tracer) was identified by the service as having one stage-two pressure injury. Review of photographs and documentation during the audit, indicated that the resident also had one stage-three pressure injury and one stage-four pressure injury. One further resident had a wound that had not been identified as a pressure injury but photographic evidence, interviews with the RNs and review of the documentation identified that this was a stage-three pressure injury (now resolved to stage-two). For both residents, staff had not correctly assessed/identified or graded the PI, and a comprehensive assessment had not been completed. The GP had reviewed the wounds however no referral had been made to a wound nurse specialist. Care plans and short-term care plans did not reflect the pressure injury needs.</p> | <p>i) Two of six files reviewed (hospital) for residents with weight loss did not have the interventions that were documented in the progress notes by the dietitian (one several weeks before and one three days before the audit) implemented or transferred to the nursing care plan or communicated to the kitchen.</p> <p>ii) One hospital resident with three skin tears had a combined wound care plan for the three wounds (skin tears) all sustained following a fall. An initial assessment was documented for each wound; however, each wound did not have a separate management plan or a wound evaluation documented with each dressing change.</p> <p>iii) Five of ten wound care plans (hospital) did not have the initial assessment documented fully and an assessment of the wound consistently documented with each dressing change.</p> <p>iv) Three of six pressure injuries had not been staged correctly and interventions to manage the pressure injury had not been fully and consistently documented.</p> | <p>i) Ensure that all interventions documented by allied healthcare staff in the progress notes are transferred to the nursing care plans and implemented and all changes to dietary requirements are communicated to the kitchen.</p> <p>ii) Ensure there is a separate wound care management plan for each wound.</p> <p>iii) Ensure that all initial wound assessments, wound assessments and each dressing change are documented fully.</p> <p>iv) Ensure that</p> |
|---|------------------------|--|---|--|

| | | | | |
|--|---------------|--|---|---|
| | | | | <p>all PIs are fully assessed and correctly staged and the care plan interventions reflect the required pressure injury management needs.</p> <p>30 days</p> |
| <p>Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p> | <p>PA Low</p> | <p>The nursing care plan records interventions and evaluations in the same section of the care plan. Previous interventions documented in the nursing care plan are not always updated or deleted when the review identifies a change in care needs. All evaluation comments need to be read to identify the current interventions required to meet the assessed care needs. The lifestyle care plan (summary document) is not always updated with a change in care needs.</p> | <p>i) Required changes to interventions are documented in the evaluation section but the interventions at the beginning of each section of the care plan are not updated when needs change</p> <p>ii) Lifestyle care plans (summary document) had not been updated for five residents (four hospital and one rest home) with weight loss, a change in dietary requirement, wounds and infections.</p> | <p>Ensure that any changes made to the interventions as part of the care plan evaluation are updated and correctly recorded in all areas of the care planning documentation.</p> <p>90 days</p> |

Specific results for criterion where a continuous improvement has been recorded

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

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

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

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

End of the report.