# Level Fifty-Two Limited

## 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 HealthShare Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Level Fifty-Two Limited

**Premises audited:** Camellia Resthome

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 20 February 2017 End date: 20 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:** 30

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
| --- | --- | --- |
|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Camellia Rest Home can provide care for up to 30 residents. This certification audit is conducted against the Health and Disability Service Standards and the service contract with the District Health Board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The facility manager is responsible for the overall management of the facility and is supported by the clinical team leader. Data is collected with this able to be used to improve service delivery.

Requirements identified at the previous audit around storage of medicines when these are administered by a resident and dating and signing of prescribed medication have been addressed. Requirements identified at the previous audit around the quality plan and review of medication remain.

Improvements are required to the following: advance directives; analysis of data with information used to improve the service; documentation of incidents; an orientation programme for registered nurses; allocation of staff to meet acuity of resident need; interRAI assessments; care planning; medication competencies for registered nurses; food services; and storage of chemicals.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Staff are able to demonstrate an understanding of residents' rights and obligations with a philosophy of open disclosure in practice. The service has a documented complaints management system available to use however there have not been any complaints to date. Information regarding the complaints policy and process is available to residents and their family.

## 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. |

The organisation's mission statement and vision is provided to residents and family. There is a quality and risk framework with systems and processes that include an internal audit process, complaints management, resident and relative satisfaction surveys, and incident/accident and infection control data documented. Corrective action planning is implemented with evidence of resolution of issues. Quality and risk management activities and results are shared among staff, residents and family.

There are human resource policies implemented around recruitment, selection with staff training provided.

## Continuum of service delivery

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

The initial assessments and care plans are used by staff while the long-term care plan is developed over the first three weeks. Care plans are evaluated six monthly. Relatives are notified regarding changes in a resident’s health condition. An activities programme is documented at the beginning of each week with a range of activities provided. Independence of each resident is encouraged.

Medicine management policies and procedures are documented and residents received medicines in a timely manner. Medication competencies are completed annually for health care assistants.

Food services are managed by a chef and baker with a four-weekly rotating summer and winter menu reviewed by a dietician. Residents confirm that food is tasty and meets their individual needs.

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

All building and plant comply with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks.

## 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. |

The restraint minimisation programme defines the use of restraints and enablers with a policy of no restraint implemented. The service does not use any form of restraint in their service. No residents use enablers currently.

## 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. |

Infections are investigated with any infection documented on a log. The surveillance data is collected monthly with data presented at the monthly staff meeting.

## 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 | 5 | 1 | 6 | 5 | 0 | 0 |
| **Criteria** | 0 | 29 | 1 | 8 | 6 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | There is an informed consent policy and procedure that directs staff in relation to the gathering of consent for sharing of information. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.  All resident files identified that informed consent is collected.  Staff confirmed their understanding of informed consent processes.  The service information pack includes information regarding informed consent. The facility manager or the registered nurse discusses informed consent processes with residents and their families during the admission process.  The policy and procedure includes guidelines for consent for resuscitation/advance directives. A review of files noted that all had signed advance directives however these are signed as being reviewed annually by the registered nurse. Documentation to confirm competency of the resident signing for an advance directive is not completed. This standard has been opened during the surveillance audit to identify the requirements to advance directives. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints with the staff and manager confirming an openness to discuss any concerns. Residents and family interviewed state that they would approach the facility manager of registered nurses if there were any concerns.  Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education.  There is a complaints register to record the complaint, dates and actions taken. There are no outstanding complaints at the time of audit.  There have been no complaints lodged with external authorities since the last audit as confirmed by the facility manager. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guided staff on the process to ensure full and frank open disclosure was available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in accident/incident forms reviewed.  Family contact is recorded in residents’ files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to participate in the entry process for their family member and in ongoing care options.  Interpreting services are available from the district health board. There are no residents requiring interpreting services.  The information pack is available in large print and this could be read to residents.  Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All were signed on the day of admission. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service provides rest home level of care under the aged care contract. The service can provide support for a maximum of 30 residents with all beds occupied on the day of the audit. Twenty-nine residents are identified as requiring rest home level care including one using respite services and one resident is receiving cares under a post admission acute convalescent care contract.  Camellia Rest Home has a management team including the owner and facility manager who provide support and operational management to the service. The owner visits once or twice a week to discuss issues, progress and attend to maintenance. They also attend the monthly staff meeting.  There is a clear mission, values and goals. These are communicated to residents, staff and family through information in the welcome pack and in staff training.  The facility manager has over 20 years’ administration experience with over three years’ experience in aged care services. Two registered nurses support the facility manager with clinical oversight. The facility manager personnel file indicates that the manager has attended education relevant to the role with the manager having completed training in business studies. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | Camellia Rest Home uses the quality and risk management framework that is documented to guide practice. An external contractor has developed the policies and procedures with these updated yearly to two yearly and as changes occur. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. A quality plan has been documented with review intended to take place in 2016. The requirement identified at the previous audit has been met however further actions are required around review and documentation of a quality plan for the current period.  Service delivery is monitored through complaints, review of incidents and accidents and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes collection and documentation of data in the staff meeting minutes as sighted in minutes reviewed. Analysis and review of trends is not always occurring.  Meeting minutes’ evidence communication with all staff around aspects of quality improvement and risk management. There are also monthly resident/family meetings that keep residents informed of any changes. Staff report that they are kept informed of quality improvements. A survey for residents and family has been sent out in 2017 and the facility manager is waiting for these to be returned. The surveys are completed annually.  The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly and quarterly through the facility checks. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Low | Policy identifies that the organisation requires all incidents, accidents and adverse events to be reported immediately. Responsibilities are clearly identified.  The facility manager understands their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. Staff state they report and record all incidents and accidents and that this information is shared at all levels of the organisation, including any follow up actions required. All incidents reviewed indicate that they are reviewed by a registered nurse and/or the facility manager.  Incident and accident reporting processes are documented and any corrective actions to be taken are shown on the forms used by the service however some incidents were identified in resident records and these are not documented on an incident form. Incidents related to challenging behaviour may be documented on a monitoring form, in progress notes or an incident form and therefore some incident are not able to be captured in the incident reporting data. Improvements are required to the incident reporting process. Falls management strategies are implemented for residents who have falls.  Families are notified of any adverse, unplanned or untoward events at times they have nominated. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.  Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff are police vetted upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Health care assistants complete an orientation programme with newer staff able to describe a buddying system and reading of policies. Registered nurses work together to orientate each other into the service however a formal process is not documented. Competencies are completed annually around medication. All staff have a performance appraisal completed annually.  Staff undertake training and education related to their appointed roles with an annual training plan documented. Education records are retained in staff files and in training records. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | Policy identifies staffing levels and skill mix with these maintained to meet residents’ needs. There are two registered nurses on duty throughout the week for a total of 44 hours per week. There are three health care assistants rostered on a morning shift and two in the afternoon with an extra short shift to support residents over dinner time (three hours). There is one health care assistant allocated for seven hours overnight and this does not consider acuity of all residents.14 health care assistants.  There are 25 staff employed that includes a cleaner, laundry assistant, a chef and baker, two registered nurses and  The facility manager and registered nurses report that additional staff would be rostered to meet residents’ needs and this was confirmed by staff interviewed. A review of past rosters indicates that staff are replaced when on leave. Staff confirm there are adequate staff on each shift apart from overnight. Residents interviewed stated that all their needs have been met in a timely manner.  There is always at least one staff member rostered on to each shift with first aid qualifications. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medicine management policies and procedures are in place and include processes for safe and appropriate prescribing, dispensing and administration of medicines. The medicines room is free from heat, moisture and light, with medicines stored in original dispensed packs, in a locked area. Medicine charts list all medications the resident is taking, including name, dose, frequency and route to be given. The general practitioner signs individual prescriptions. The entries are not block-dated and allergies are recorded. The requirements identified at the previous audit have been met.  All charts have photo identification with verification that the photograph is a true and correct likeness. Discontinued medicines are signed for however three monthly GP reviews are not consistently evident in the medicines administration charts. The previous requirement remains.  Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current, correct and reviewed. There is a requirement around signing for administration of controlled drugs.  Sharps bins were sighted. When new medication is delivered, the registered nurse documents reconciliation of the medicines. The requirement at the previous audit has been met. The pharmacy collects unwanted or expired medications.  Medication administration was observed. Education in medicine management is conducted. Health care assistants are authorised to administer medications through completion of the medication competency. Staff administering medications on the day of audit were observed to crush medications however instructions around this were not documented. An improvement is required.  Self-administration of medicine policies and procedures is in place. There are no residents who self-administer their medication apart from a resident who carries the inhaler with them. The resident has a competency assessment completed and signed off by the general practitioners. Staff state that any resident who self-administers medication would have a secure/lockable storage for their medicines. The requirement identified at the previous audit has been met. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | The residents’ individual food, fluids and nutritional needs are met. Residents are provided with a well-balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked on-site by a chef and baker who prepare meals for the weekends. The meals in the weekends are reheated and served by specific staff who should have food safety training.  The dietician reviews the menu which is based on nutritional guidelines for the older people in long-term residential care. Recommendations identified by the dietician are documented as having been completed. Information is shared with kitchen staff around needs, food allergies, likes, dislikes and special diets however these have not been updated or reviewed. The facility provided modified diets for example puree diets to meet the dietary needs of the residents. Observation of the food service during the audit indicates that the food is described as tasty, served hot and meets needs of residents.  Labels and dates on all containers and records of food temperature monitoring is maintained. The fridge and freezer temperatures are monitored however there is no indication that temperatures are adjusted when these are outside of the normal range. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Residents received adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions are documented for each goal in the long-term care plans (refer 1.3.8.3). Interventions are documented when specific needs are identified, for example, around pain management, appropriate footwear and hearing aids.  An interview with the GP confirms that clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long-term care plan as per individua need. This includes support from a podiatrist and assessment service coordinators.  Resident and family involvement in the development of goals and review of care plans is encouraged.  At times, there is a standardized approach to documentation of strategies to meet needs and short term plans have not been used since the appointment of new registered nurses three months prior to the audit. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | The activities programme for the past six months as documented in the activity diary confirms that independence is encouraged with choices offered to residents. The activities coordinator prepares the activity programme a week in advance. The programme for the week is displayed on a board in the resident area. Different activities are provided with these including a focus on physical, mental, spiritual and social aspects of life. During the onsite visit, residents were observed to participate in activities with some choosing to engage in their own individual activities. One newer resident confirmed that they had been reminded of the activities scheduled for the day and had elected to stay in their room as they had not been feeling well.  On admission, the activities coordinator completes an assessment and plan with residents and family confirming that they have input into this. The plan is at times generic and does not always include specific interventions relevant to the needs of an individual. Attendance records are maintained daily and the activities coordinator writes a monthly review for each resident along with six monthly review of the plan. Currently the assessment and plan is not completed for all residents as the interRAI assessment and care plan is being completed however observation of the completion of an interRAI assessment and care plan on the day of audit included consultation with the activities coordinator around social activity for the resident (refer 1.3.3.1).  Residents and family interviews confirm they enjoy the variety of activities and are satisfied with the activities programme. Activities included outings as well as community involvement. Family are encouraged and supported to take their family member into the community. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | The resident files reviewed include plans that are reviewed six monthly. Progress notes are documented at the end of each shift with clinical notes documented by the general practitioners. Progress notes reflect daily response to interventions and treatments.  Changes to care are documented as part of the six-monthly review of the care plan however changes to the care plan as changes occur are not documented. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | Documentation identifies that all processes are undertaken as required to maintain the building warrant of fitness. The current warrant of fitness is current with expiry dated for June 2017.  Maintenance is undertaken by maintenance staff as required. Electrical safety testing occurs annually and all electrical equipment sighted has an approved testing tag. Clinical equipment is tested and calibrated by an approved provider at least annually.  The physical environment minimises the risk of harm and promotes safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. Regular environmental audits identify any areas requiring improvement.  There are external areas. Outdoor areas have shade and there is access to garden areas. Residents and family members confirm that the environment is suitable to meet their needs.  Currently chemicals are not kept in secure areas when not in use. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | An identified registered nurse is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections, for example facility-acquired infections, are documented to guide staff. Information is collected on a monthly basis and tabled at the staff meeting monthly (refer 1.2.3.6). Information gathered is documented in the infection log maintained by the infection control coordinator.  The infection control surveillance is appropriate to the size of the service. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has a policy or no restraint. Residents do not use restraints or enablers. Staff state that any use of an enabler would be voluntary and the least restrictive option for the residents. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.7  Advance directives that are made available to service providers are acted on where valid. | PA Low | Each resident file reviewed includes an advance directive. Competency to sign for an advance directive is not documented clearly and while annual review of an advance directive occurs, this is documented by the registered nurse. | Competency to document an advance directive is not documented.  The registered nurse signs for the review of an advance directive. | i) Ensure that competency to document an advance directive is completed.  ii) Ensure that only the resident signs for the review of an advance directive.  180 days |
| Criterion 1.2.3.1  The organisation has a quality and risk management system which is understood and implemented by service providers. | PA Low | There is a quality framework documented and a quality plan however this has not been reviewed in April 2016 as scheduled. A current quality plan is not documented. | The previous quality plan has not been reviewed as per schedule.  A current quality plan is not documented. | Review the 2015 to 2016 quality plan.  Document, implement and review a quality plan for the current period.  180 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Data is collected and documented using templates provided. The data is tabled at the monthly staff meetings however there is limited documentation of discussion of data. The health care assistants and registered nurses interviewed can describe discussion of data. The registered nurses interviewed confirm that they discuss data with staff individually, through handover and at staff meetings. | Data is not always analysed with review of trends leading to quality improvement. | Analyse data and review trends to improve service delivery with documentation of discussion at staff meetings.  180 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | An incident form is used to document any incident. The health care assistants interviewed confirm that they document an incident. Incidents relating to challenging behaviour may be documented in progress notes, on a challenging behavioural monitoring form or on an incident form. Not all incidents around challenging behaviour are able to be collated in monthly data. This potentially leads to insufficient analysis of incidents (refer to 1.2.3.6) | Not all incidents are documented using an incident form and some incidents are recorded using different mechanisms with data not currently used to improve service delivery. | Ensure that incidents are documented with data used to improve service delivery.  180 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Health care assistants receive an orientation however a programme for new registered nurses is not documented. The two registered nurses have been employed in quarter two of the current financial year and state that they had previous experience in nursing that supported their transition to their new service. They also stated that they had read policies and procedures. | Registered nurses do not have a documented orientation programme indicating that they have completed an orientation relevant to their needs. | Ensure that any new registered nurse completes an orientation programme.  180 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | There is one health care assistant on duty overnight. There is an on-call system with a registered nurse able to be called to come in at any time. Staff state that the on-call staff are responsive to their needs.  There are two registered nurses on duty throughout the week for a total of 44 hours per week. There are three health care assistants rostered on a morning shift and two in the afternoon with an extra short shift to support residents over dinner time (three hours). There is one health care assistant allocated for seven hours overnight and this does not consider acuity of all residents.  Staff and registered nurses state that there are three residents who require support for transfer and mobility with the use of a standing hoist. The health care assistants interviewed state that at times they do not have the capacity to access two staff when using the hoist. Staff are also required to support residents who have challenging behaviour and residents with other needs who at times require immediate support with other staff supporting all other residents.  The facility manager is aware of the issues related to acuity of residents and states that the owner has been alerted. | Staffing overnight in particular does not reflect the acuity and needs of all residents. | Review the rostering of staff to ensure that staffing reflects the acuity of residents and resident need.  60 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Health care assistants give medications and have an annual medication competency completed. Registered nurses provide oversight of administration of medication. | The registered nurses do not have a medication competency completed but provide oversight of administration of medicines. | Ensure that each registered nurse has an annual competency.  30 days |
| Criterion 1.3.12.6  Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines. | PA Moderate | Each general practitioner documents the frequency of medical review with this expected to occur as documented.  Staff observed to administer medication on the day of audit crush medicines however instructions for this to occur are not documented.  When controlled drugs are administered, there are two signatures in the controlled drug register however only one staff member signs the administration chart. | Four of the ten medicines charts reviewed did not show evidence of the medicines having been reviewed within the previous three months. This requirement remains from the previous audit.  Only one staff member signs for administration of controlled drugs when these are given.  Some medicines are crushed however indications for this are not included in the prescription. | Ensure that review of medications occurs three monthly or as per frequency documented in the resident file.  Ensure that the medication administration sheet is signed by two staff when controlled drugs are administered.  Ensure that the general practitioner documents any requirement for crushing of medications.  30 days |
| Criterion 1.3.13.2  Consumers who have additional or modified nutritional requirements or special diets have these needs met. | PA Low | Kitchen staff who serve food have not all had food safety training. Kitchen staff have had training around hand hygiene as part of orientation and ongoing training. | Not all kitchen staff have completed food safety training. | Ensure that all kitchen staff have completed food safety training.  180 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Fridge temperatures are taken and documented with most within normal range. Freezer temperatures have been taken in the past. The cook states that they check the temperatures informally and the temperatures were observed to be within appropriate range on the day of audit. | Corrective actions are not taken when fridge and freezer temperatures are identified as not being within normal range. | Ensure that all fridge and freezer temperatures remain within normal range.  180 days |
| Criterion 1.3.3.1  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function. | PA Negligible | There is one registered nurse in training to complete interRAI assessments. A registered nurse has been employed as a consultant to help the registered nurse complete the interRAI assessments. New residents are admitted with an interRAI assessment completed by the needs assessment service. An assessment is completed by the registered nurse including either an initial assessment or as part of the evaluation prior to review of a care plan. The facility manager has accessed the interRAI team to fast track the new registered nurse into training and once this is completed, the aim is to fast track the second registered nurse into training. Both registered nurses are newly employed. Five residents have an InterRAI assessment. | Not all residents have an InterRAI assessments completed to date. | Ensure that interRAI assessments are completed for each resident as scheduled.  180 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Short term needs are identified. In the past (prior to the last three months) short term plans have been used to document short term cares.  Some strategies are documented to manage need however some care plans include generic strategies particularly when these relate to management of challenging behaviour and some short-term needs. | Short term care plans are not always completed when needs arise for example wound management plans, urinary tract infections, skin tears.  Documentation of individualised strategies to meet resident needs is not always completed. | i) Document short term care plans when needs arise.  ii) Ensure that care plans include sufficient interventions or strategies to manage assessed need.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | An assessment and activity plan is documented for each individual resident with evidence of review monthly and six monthly. The plans are at times generic and do not reflect individual needs. The programme is documented on a weekly basis and displayed on a board in the resident area. The activity plan for an individual resident does not always include activities relevant to their individual needs particularly when there are behaviours that challenge. | Individualised interventions are not always documented in activity plans.  An activities programme is not documented for a sufficient length of time that would allow residents and family to plan ahead. | Document individualised activity plans for each resident with these reviewed in line with review of the care plans.  Document an activity programme on at least a monthly basis.  180 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Resident needs are documented in the resident records. At times changes are documented in progress notes, in doctor records and in other documentation however the long-term care plan is not always updated as changes occur. | The long-term care plan is not always updated as changes occur. | Ensure that the long-term care plan is updated as changes occur.  90 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | Chemicals are left in a hallway and an unlocked cupboard when not in use. The cleaner and staff state that this is usual practice. | Chemicals are not locked in a secure area when not in use. | Ensure that chemicals are kept in a secure area when not in use.  30 days |

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

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

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

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

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End of the report.