

# Inglewood Welfare Society Incorporated - Marinoto Rest Home

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## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** Inglewood Welfare Society Incorporated

**Premises audited:** Marinoto Rest Home

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

**Dates of audit:** Start date: 2 June 2017 End date: 2 June 2017

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit: 19**

# Executive summary of the audit

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## 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

Marinoto Rest Home is owned by the Inglewood Welfare Society. The Board employs a facility manager to oversee the daily operations of the home. The service provides rest home level of care for up to 25 residents. On the day of the audit there were 19 residents.

The residents, relatives and general practitioner commented positively on the care and services provided at Marinoto Rest Home.

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

The facility manager (registered nurse) has a background in clinical and management roles within the primary health sector and has been in the role since January 2017. She is supported by two registered nurses and an assistant manager.

The service has addressed 11 of 14 previous certification findings relating to: relative notifications of incidents; dates and signatures on clinical records; admission agreement; assessments; service integration; medicine management; infection control coordinator training; and surveillance.

There continues to be improvements required around timely provision of service, care plan interventions and the infection control programme remain.

This audit identified further areas for improvement around complaints, internal audits and education.

## 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.
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Policies are implemented to support residents' rights, communication and complaints management. Regular resident meetings are held. Resident/relative surveys provide an opportunity for feedback on the services. Open communication is encouraged and management operate an open-door policy. Complaint forms and information is readily available.

## 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 low risk.
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The quality and risk management programme includes service philosophy, goals and a quality/business plan. Quality data is collated and trended to identify areas for improvement. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed up. An education and training programme is in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is a comprehensive admission package. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan documenting supports, needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrate service integration. Resident files include the general practitioner, specialist and allied health notes.

Medication policies reflect legislative requirements and guidelines. Staff that are responsible for administration of medicines, complete annual education and medication competencies. The medicine charts sampled are reviewed at least three-monthly.

One activity coordinator oversees the activity programme for the residents. The programme runs during the day over five days and health care assistants provide activities on the weekends.

There is a well-equipped kitchen and all meals and baking are done on-site. Residents' food preferences, dietary and cultural requirements are identified at admission and accommodated. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met.

## 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.
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The building holds a current warrant of fitness (expiry 8 April 2018).

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Marinoto Rest Home has restraint minimisation and safe practice policies and procedures in place. During the audit, there were no residents using restraints or requiring enablers. The registered nurses share the restraint coordinator responsibilities.

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

## 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)
<b>Standards</b>	0	15	0	5	2	0	0
<b>Criteria</b>	0	39	0	5	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>The service has a complaints policy that describes the management of complaints process. Complaint forms are visible and available. Information about complaints is provided on admission. Interview with relatives and residents demonstrates an understanding of the complaints process. Two healthcare assistants (HCA) and two registered nurses interviewed were able to describe the process around reporting complaints. There is a complaint register. Two written complaints for 2016 have been investigated within the required timeframe and to the satisfaction of the complainant. Staff meeting minutes identify discussion around a relative's verbal concern, however, this had not been entered or investigated as per the complaints policy.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Five residents and three relatives interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Seven incident/accident forms reviewed include documented evidence of family notification or noted if family did not wish to be informed. The previous finding around notification of relatives following incidents has been addressed. Resident meetings are held regularly and evidence discussion on all services provided. Resident and relative newsletters commenced in February and will be quarterly. Interpreter services are available as required.</p>

conducive to effective communication.		
<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Marinoto Rest Home is owned and operated by the Inglewood Welfare Society since July 2015. The business had been previously leased for 21 years. The Board of Trustees (one of whom was interviewed) have appointed a manager to oversee the daily operations of the home. The new facility manager was appointed in January 2017. Marinoto provides rest home level of care for up to 25 residents. On the day of the audit, there were nineteen residents including one resident under sixty-five years. All residents (including the under 65 years of age resident) are under the aged related residential care contact (ARRC). There are no respite care residents.</p> <p>The manager is a registered nurse (RN) with a current practising certificate and has a post graduate master of nursing. This is her first aged care role; however, she has had many years of clinical and management experience in primary health care. The facility manager is supported by two RNs who job share over seven days week on day shift. A non-clinical assistant manager is employed Monday to Friday.</p> <p>There are six board members who meet monthly and have the ability to co-opt to other members as required. The facility manager reports directly to a board subcommittee who meet monthly and are available to the facility manager as required at other times.</p> <p>The Inglewood Welfare Society has an overall business/strategic plan 2016 – 2018. The business plan includes the vision and key objectives for Marinoto. The business plan is reviewed at board meetings and at the annual general meeting.</p> <p>The manager has attended at least eight hours of professional development that relates to managing a rest home, including attending a manager training day; leadership in aged care and DHB provider forums.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>There is a business/strategic plan that includes quality goals and risk management plans for Marinoto Rest Home. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies and procedures have been developed by an external aged care consultant. Staff interviewed confirm they are made aware of any changes to policies through staff meetings.</p> <p>Data is collected in relation to a variety of quality activities, including accidents/incidents, falls and infection control. Information and graphs are displayed on the staff noticeboard and staff meeting minutes' evidence discussion around trends and corrective actions.</p> <p>The internal audit programme continues to be implemented, however, not all corrective actions have been followed up and signed off. Outcomes of internal audits have not been discussed at meeting minutes.</p> <p>Residents/relatives are surveyed annually to gather feedback on the service provided. The survey is due in June 2017.</p>

		<p>There are implemented risk management and health and safety policies that have been reviewed to include the new health and safety legislation. The facility manger has attended a health and safety update as part of a manager study day. Health and safety is a set agenda item at the monthly staff meeting. Minutes evidence discussion around incidents, falls and hazard management. Analysis of accident/incidents include the time of incidents. There is a current hazard register. The service is in the process of nominating a health and safety representative who will then attend the required training.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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 accidents and incidents reporting policy. The RNs investigate accidents and near misses and analysis of incident trends occurs. The registered nurses (RNs) complete clinical follow up of residents. Seven incident/accident forms reviewed demonstrated that appropriate clinical follow up and investigation occurred following incidents. Neurological observations have been completed following unwitnessed falls or known knocks to the head. Discussions with the facility confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been an external issued based audit around clinical oversight for the facility.</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</p>	PA Low	<p>There are human resources management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (two RNs, two HCAs and one activity coordinator). All files evidenced that reference checks have been completed prior to employment. Annual staff appraisals are evident in four of five staff files reviewed. One staff member was not due for an annual appraisal. All files reviewed evidence signed job descriptions. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believe new staff are adequately orientated to the service.</p> <p>The in-service education programme for 2016 has been completed and the plan for 2017 is in place. The physiotherapist provides safe manual handling for staff. Not all mandatory training has been offered in the last two years.</p>

legislation.		One RN has completed the interRAI training and the other RN is in the process of completing the training.
<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>Staff rostering and skill mix policy is in place. Staff are rostered on to manage the care requirements for residents in the rest home. The facility manager and assistant manager (a qualified HCA) are on duty Monday to Friday on day shift. Two registered nurses cover the seven-day week on morning shifts. The manager and RNs share the on call.</p> <p>There are two HCAs on full shifts for morning, afternoon and night shifts. There is a short shift kitchenhand/HCA on the mornings and afternoons. There is a dedicated cleaner on Monday to Friday and kitchen staff carry out cleaning duties in the weekends when they have finished in the kitchen. The activities coordinator is on duty from 8.30 am – 4.30 pm Monday to Friday.</p> <p>Interviews with HCAs, relatives and residents confirm that staffing is adequate to meet the needs of residents. There is at least one staff member with a current first aid certificate on duty at all times.</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>	FA	The resident files are appropriate to the service type. All documents and care plans including updates, identified the RN (by signature) who updated the care plan/clinical record and the date amendments have been made. The previous finding has been addressed.
<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</p>	FA	Residents and relatives confirm they received information prior to admission and had the opportunity to discuss the admission agreement with the owner/manager. The admission agreement in use has been developed by an aged care association and aligns with the requirements of the aged related residential contract (ARRC). Exclusions from the service are included in the admission agreement. The previous finding around the admission agreement has been addressed. Residents and relatives confirmed the service agreement is discussed with them.

identified.		
<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>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Staff who administer medications have been assessed for competency on an annual basis. Medications received (blister packs) are checked on delivery by both RNs. All medications are stored safely. All eye drops are dated on opening. The medication fridge is monitored weekly.</p> <p>Ten of ten medication charts sampled meet legislative prescribing requirements. The GP has reviews the medication charts three-monthly. Administration records demonstrate that all medications are signed as administered. Residents who self-administer have medication competencies checked three-monthly by the GP and RN. Medication errors are documented on incident forms and investigated with competencies of staff being reviewed where appropriate. The internal auditing programme includes medication audits completed by RNs.</p> <p>The previous findings around: GP reviews of medication charts; signing of six-monthly audits; medication reconciliation; glucagon for diabetic emergencies; medication competencies; self-medication; and compliance of administering medications, have all been addressed.</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 Marinoto are prepared and cooked on-site in a well-equipped kitchen. Two cooks cover seven days a week. Kitchen hands provide support. The kitchen staff have not all completed food safety or chemical safety education (link 1.2.7.5). There is a four-weekly seasonal menu which has been reviewed by a dietitian in November 2016. Food preferences are met and staff can access the kitchen at any time to access food for residents as required. The cook receives a dietary profile of resident dietary requirements and any likes or dislikes including updates. Special diets including modified foods and diabetic diets are catered for.</p> <p>Fridge, freezer and end cooked temperatures are monitored weekly. A cleaning schedule is maintained. Chemicals are stored safely within the kitchen.</p> <p>Resident meetings along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed are very satisfied with the food and confirm that alternative food choices are offered.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and</p>	FA	<p>All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Risk assessment tools are completed and the outcome of assessments forms the basis of the care plan.</p> <p>In resident files sampled where pain was identified, a pain assessment has been completed. Wound assessments are in place for wounds. The previous finding around pain assessments has been addressed (link to 1.3.6.1 for effectiveness of analgesia) and wound assessments has been addressed. InterRAI assessments had not been</p>

recorded in a timely manner.		completed within the required timeframes (link 1.3.3.3).
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Four of five resident files sampled have a documented long-term care plan in place to guide care. The long-term care plans include supports and needs to meet the resident goals. The outcomes of the risk assessments are reflected in the four long-term care plans.</p> <p>One resident did not have a long-term care plan documented and intervention were not documented for all identified issues; this previous finding remains open.</p> <p>In all files sampled where there was a hospital discharge summary, the discharge summary instruction had been transferred to the long-term care plan. The previous finding around service integration has been addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>When a resident's condition alters, the RN initiates a review and if required, a GP consultation. There is evidence that family members 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. Discussions with families are documented in the resident's progress notes.</p> <p>Adequate dressing supplies are in the treatment room. Wound management policies and procedures are in place. Initial wound assessments and ongoing evaluations are in place for one resident with multiple skin lesions. There is a range of equipment readily available to minimise pressure injury. There were no pressure injuries on the day of audit. There is access to a wound nurse specialist at the DHB as required. Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified.</p> <p>Short-term care plans document appropriate interventions to manage short-term changes in health such as infections.</p> <p>Monitoring forms are used, for example: observations; behaviour; blood sugar levels; and neurological signs. Pain assessments are documented for each of the resident files reviewed, however there is no documented follow-up for the effectiveness of analgesia administered.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity</p>	FA	<p>An activities coordinator (AC) typically works a minimum of 35 hours per week Monday to Friday. Healthcare assistants assist with individual and group activities during the week and on weekends. The activities programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes: van outings; church services; games; gardening; and exercise. Local kindergarten and school groups visit. Recently residents held a market day including: a cake stall; garage sale; raffles; craft stall; and with local community providing some other stalls. A local retirement home visits and vice versa where they run</p>

<p>requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>competitions. There is a men's club, where they discuss male orientated interests and plan activities. Van outings take residents to local sites of interest. On the day of audit residents were observed participating in a variety of activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities.</p> <p>The activities coordinator is responsible for the resident's individual activity care plans which are developed within the first three weeks of admission. The resident/family/whānau as appropriate, are involved in the development of the activity plan. Resident files reviewed identify that the individual activity plan is reviewed six-monthly and evidence outcomes achieved against goals set.</p> <p>Activities are planned that are appropriate to the functional capabilities of residents and are mostly driven by resident requests. Residents provide feedback individually and make suggestions for activities at the resident meetings and via annual resident satisfaction survey.</p> <p>Residents and families interviewed report satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The registered nurse evaluates care plans when there is a change in health status. Care plans are not always evaluated twenty one days after admission or six monthly (also link 1.3.3.3). Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing. The GP reviews the residents at least three monthly or earlier if required.</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 that expires 8 April 2018. The dining room has been upgraded and includes new dining furniture.</p>
<p>Standard 3.1: Infection control management</p>	<p>PA Low</p>	<p>The infection control programme and its content and detail, is appropriate for the size and degree of risk associated with the service. The scope of the infection control programme is available. The programme has not been reviewed annually.</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>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The two RNs are responsible for coordinating/providing education and training to staff. Both infection control coordinators have a job description that defines their responsibilities for infection control including staff education. Both infection control coordinators have completed the online MOH training. One infection control coordinator attended a DHB study day in April 2017 which included infection control. The second RN is registered to attend the DHB study day in August 2017. The previous finding has been addressed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. Infection control reports for resident infections are collated and entered onto a monthly infection summary. This data is monitored and analysed for trends monthly and six-monthly. An infection analysis and graphs are available for all staff. The previous finding around trending of data has been addressed. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. During the audit, there were no residents using enablers or requiring restraint. Restraint minimisation is overseen by two RNs. Education on restraint minimisation and managing challenging behaviour has not occurred within the last two years (link 1.2.7.5).</p>

minimised.		
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## 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 1.1.13.3 An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.	PA Low	The complaint register includes two written complaints, investigation, follow up within the required timeframes and actions taken. One verbal concern was not entered into the complaint register.	Discussion around a relative verbal concern was identified in a staff meeting. The verbal concern had not been entered into the complaint register, investigated, followed up and resolved to the satisfaction of the complainant.	Ensure all verbal concerns are managed in line with the complaints procedure.  90 days
Criterion 1.2.3.8 A corrective action plan addressing	PA Low	Internal audits have been completed as per the internal audit schedule. Audits cover all areas of service including environmental, clinical, food services, infection control and medications. Non-compliance is identified but not followed	Internal audits cover all areas of the service. Corrective actions have been identified and documented. There is no documented evidence that corrective	Ensure corrective actions are completed

areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.		up with staff and actioned.	actions have been completed and signed off for internal audits with less than 100% compliance. There is no documented evidence that the outcomes of internal audits have been discussed at staff meetings.	and signed off. Ensure outcomes of internal audits are documented in meeting minutes.  90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There is an annual education plan in place which covers mandatory training over a two-year period. Five staff files were reviewed. Competencies had been completed such as medication, fire and safety questionnaire, health and safety questionnaire and hand hygiene competencies. The RNs have attended a palliative care study day. Not all mandatory training requirements have been completed.	The cooks have completed food safety unit standards. However, other staff involved in food preparation have not completed food safety or chemical safety training. Care staff have not completed skin care, prevention of pressure injuries, restraint minimisation and safe practice within the last two years.	Ensure mandatory education is completed as scheduled.  90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	The registered nurse completes an initial assessment within twenty four hours of admission and documents the initial care plan. Five of five files sampled did not have a current interRAI assessment where this was required. Until recently, only one of the two RNs was trained in interRAI assessments, due to a change in staffing. The second RN is currently completing interRAI training. Not all interRAI assessments reviewed were completed within 21 days of admission or six monthly as required. The previous finding remains open.	Five of the five interRAI assessments had not been completed as required (one interRAI assessment was not completed within twenty one days of admission; four had not had interRAI assessments completed six monthly).	Ensure that contractual timeframes around resident assessments and interRAI assessments are met.  60 days
Criterion 1.3.5.2	PA	The long-term care plans reviewed described ADLs to meet	(i)One new resident file did not have a	(i) Ensure

<p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>Moderate</p>	<p>the resident's goals and needs and identified allied health involvement. Not all care plans identified all interventions to manage current risks. One resident newly admitted (been in the facility longer than five weeks) had no documented long term care plan</p>	<p>LTCP completed.  (ii)One resident file for a resident with a chronic wound did not document the management of continence, nutrition and skin integrity.</p>	<p>long-term care plans are completed for all residents.  (ii) Ensure that interventions are documented for all resident identified needs  30 days</p>
<p>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.</p>	<p>PA Low</p>	<p>For resident files reviewed staff (registered nurses and caregivers) could describe care required to meet resident assessed needs. However files reviewed did not always document resident outcomes.</p>	<p>There was no documented evidence of the effectiveness of analgesia given for a resident requiring prn analgesia.</p>	<p>Ensure effectiveness of analgesia is documented.  60 days</p>
<p>Criterion 3.1.3  The organisation has a clearly defined and documented infection control</p>	<p>PA Low</p>	<p>Infection control is discussed at the monthly staff meeting and includes discussion about infection control matters. The scope of the programme is outlined in the infection control policy, however the programme has not been reviewed. The previous finding remains.</p>	<p>The infection control programme has not been reviewed in the last 12 months.</p>	<p>Ensure the infection control programme is reviewed at least</p>

programme that is reviewed at least annually.				annually.  60 days
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.