# Jane Mander Retirement Village 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Jane Mander Retirement Village Limited

**Premises audited:** Jane Mander Retirement Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 27 January 2015 End date: 28 January 2015

**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:** 104

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Jane Mander Retirement Village Limited is located in Whangarei. The village includes a residential care facility that provides care for up to 142 residents at hospital, rest home, and dementia levels of care. On the day of the audit there were 104 residents living at the facility.

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. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The two areas identified for improvement at the last certification audit relating to the documentation of clinical care and medicines management remain. One additional area for improvement is in regards to communicating quality and risk management activities with staff.

## Consumer rights

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

Residents and their families are kept informed of any adverse event or change in health status. Interpreter services are available if needed.

The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth by the Health and Disability Commissioner.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

A quality and risk management plan has been developed for the service which includes clinical and operational key performance indicators. The service has policies and procedures to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Key components of the quality and risk management system include monitoring all adverse events. Data that is collected is analysed and evaluated. Quality and risk activities are not consistently being documented in the staff meeting minutes and is a required improvement.

The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. There is an annual education schedule that is being implemented. In addition, opportunistic education is provided. Aged Care Education is in place for the caregivers. Education and training for registered nurses is supported by the Northland District Health Board.

The facility is adequately staffed. Registered nursing cover is provided 24 hours a day, seven days a week.

## Continuum of service delivery

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| 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 low risk. |

Service delivery is overseen by onsite registered nurses. Each resident is comprehensively assessed and interventions are planned in consultation with the resident and their families where appropriate. Plans of care are developed by registered nurses in consultation with the resident’s general practitioner. Each resident has an individual and group activities plan to maximise their health and independence. Residents are evaluated on a regular basis and at least six monthly. All residents are seen by a general practitioner within days of admission and at least three monthly. There is an established medicine management system in place. The food service meets the needs of residents. Residents and relatives interviewed spoke very highly of the care provided, the range of activities on offer and the food service. Improvements continue to be required relating to the documentation of clinical care and medicines management.

## Safe and appropriate environment

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

A current building warrant of fitness is posted in a visible location.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint policies and procedures are in place and include the definitions of restraints and enablers. The service has one resident who has voluntarily requested an enabler in the form of bedrails. Staff receive education and training relating to the use of enablers and restraint.

## Infection prevention and control

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

Infection control policies and procedures are in place. The monthly monitoring of infections is recorded, collated and analysed. The infection control co-ordinator uses the information to determine infection control activities, resources and education.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 13 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 3 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints received is maintained by the village manager using a complaints’ register. Documentation including follow up letters and resolution demonstrates that complaints are well-managed. Four written complaints were received in 2014 with evidence of appropriate and timely follow-up actions taken. All of the complaints received in 2014 are resolved. One complaint, lodged in 2015, is currently under investigation.Discussions with four rest home and three hospital residents, and eight relatives (one with family in the rest home, four with family in the dementia unit, and three with family in the hospital) confirmed they were provided with information on complaints and complaints forms.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whanau is recorded on the electronic accident/incident form and in the residents’ progress notes. Fifteen accident/incident forms that were reviewed across the rest home, hospital and secure dementia unit identified family are kept informed. All eight relatives interviewed stated that they are kept informed when their family member’s health status changes. Six-monthly family meetings are conducted for each service level.An interpreter policy and contact details of available interpreters is in place. Interpreter services have been used if needed. The information pack is available in large print and is read to residents who require assistance.Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Jane Mander Retirement Village is a Ryman Healthcare facility, situated in Whangarei. The service currently provides care for up to 142 residents at hospital, rest home, and dementia level care. There are thirty serviced apartments that are certified to provide rest home level of care. Psychogeriatric services have been discontinued. On the day of the audit there were 57 hospital residents, 27 rest home residents including four residents living in serviced apartments and 30 residents residing in the secure dementia unit. Ryman Healthcare has an organisational philosophy, which includes a vision, mission statement and objectives. Village objectives for Jane Mander Retirement Village are regularly reviewed and are updated each year. Clinical and operational key performance indicators have been determined. The village manager is a registered nurse who has been in this role for one year. Prior to this appointment, she was the clinical manager for the facility for 18 months. She recently completed a post graduate diploma in healthcare management. The village manager is supported by a regional manager and a full-time clinical manager/RN. The village manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | A quality and risk management system is being maintained. 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. A system for document control is in place. Any new policies or changes to policy are communicated to staff, evidenced in meeting minutes and in interviews with thirty staff (twelve caregivers, five registered nurses (RNs), seven activities staff, two cooks, one kitchen hand, one enrolled nurse, one health and safety officer and one volunteer).Key components of the quality management system include (but are not limited to) monitoring falls, medication errors, restraint use, pressure areas, infections, wounds and resident satisfaction. Weekly reports by the village manager to the regional manager provide a coordinated process between service level and the organisation. There are monthly accident/incident reports that break down the data collected across the rest home, dementia unit, hospital units and staff incidents/accidents. Falls prevention strategies are in place that includes the analyses of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The internal audit programme monitors key components of the service. If a target is not met or an area of noncompliance is identified, there is evidence of a quality improvement plan (QIP). Missing is documented evidence of communicating quality and risk activities and findings with staff with evidence missing in the full staff and RN meeting minutes.A comprehensive health and safety programme in place. The organisation has achieved tertiary certification through the ACC Accredited Employer Programme. |
| 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.  | FA | Individual incident reports are documented electronically for each incident/accident and are also documented in the residents’ progress notes. Documentation includes the actions taken and any follow up action required. The data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Fifteen completed incident forms were reviewed and reflected a clinical assessment and follow up by a registered nurse. Discussions with the village manager and clinical manager confirm their awareness of the requirement to notify relevant authorities in relation to essential notifications.  |
| 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.  | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Seven staff files that were reviewed (clinical manager, three caregivers, two RNs, head chef) included evidence of the recruitment process, employment contract, orientation, and annual performance appraisals.The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service.A register current practising certificates is maintained.There is an annual education schedule that is being implemented and covers more than eight hours annually. In addition, opportunistic education is provided. Aged Care Education (ACE) is required for the healthcare assistants. Post graduate education for RNs is funded by the Northland District Health Board. Discussions with staff and management confirmed that a comprehensive in-service training programme in relevant aspects of care and support is in place. Low staff attendance rates at in-services have been highlighted as an issue with strategies put forth to address this concern. There are sixteen caregivers who work in the dementia unit. Seven of these caregivers have completed the required dementia standards and four are in the progress of completing them. The remaining staff are either on extended leave or have been employed for less than six months.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The village manager and clinical manager, both RNs, work full time Monday – Friday. One RN covers the AM, and PM shift for the dementia unit with an EN or senior caregiver staffed on the night shift. They are supported by four caregiving staff on the AM and PM shifts and two caregivers on the night shift. The hospital is staffed with two RNs on the AM and PM shifts and one RN on the night shift. In addition a coordinator/RN is staffed on the AM shift (Monday – Friday). The rest home/hospital is staffed with two RNs on the AM shift and one RN on the PM and night shifts. Five caregivers are scheduled to work during the AM and PM shifts and two are scheduled to work during the night shifts.Caregiver staffing in the rest home has been identified as a concern with high absenteeism. The village manager and regional manager are implementing strategies to address this, including increasing the number of staff in the casual pool, and flexing other staff (physiotherapy assistant, fluids assistant, activities staff) to assist as required.Interviews with seven residents and eight relatives confirmed staffing overall was satisfactory. |
| 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 Low | The medicines management system is observed in practice in all areas. All charts reviewed demonstrate that the resident has been reviewed by the general practitioner within the last three months. All medicines are dispensed to the facility by a contracted pharmacy. Unused medicines are returned to the dispensing pharmacy. The storage of medicine is secure and dedicated medicine refrigeration is available. Staff have purpose-built trollies to assist in the administration of medicines. There is a system of medicine reconciliation in use for newly admitted residents. No resident was self-administering medicines at the time of audit. Medicines are being administered by registered nurses who have been assessed as competent by other registered nurses. The previous audit identified that charting by medical and nursing staff required improvement. Improvements have been made since the previous audit however further improvements continue to be required.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The onsite kitchen is staffed by two chefs (one of whom was newly appointed) and assistant kitchen staff who have completed food safety qualifications. The kitchen staff prepare food according to a pre-agreed four weekly rolling menu, which was designed and reviewed by a registered dietitian at an organisational level. All meals are cooked in the main kitchen and then transferred to the three areas in insulated containers and then decanted into pre-warmed bain maries. Caregivers serve the food from bain maries in kitchenette areas in each unit. Residents in all areas have 24 hour access to snacks including fresh fruit. Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and results recorded daily and weekly. Food safety in-service is completed bi-annually. There is a food service manual to guide staff. The kitchen is included as part of the internal audit programme. Residents with special dietary needs have a nutritional profile completed on admission. This is being reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen and noted by kitchen staff. Special diets and resident likes/dislikes are recorded on the kitchen notice board. Alternative food choices are available. Specialist eating utensils are available for residents who need these. Residents and relatives interviewed spoke highly about the kitchen service and the newly employed chef.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Interventions that matched the assessed needs of residents were documented in plans of care. When a resident's condition alters, the registered nurses conduct a review and if required, a review by the general practitioner or a specialist external consultation. Short term care plans are used where appropriate. Staff interviewed stated that they had sufficient equipment to provide care and appropriate training to use that equipment. Emergency equipment is available. Staff weigh residents at least monthly or more frequently if concerned. Weight loss is appropriately managed. All residents with wounds have documented assessments and plans of care and these are evaluated until resolved. Staff reported that they had adequate continence and dressing supplies available. Supplies of continence and wound care products were evidenced. Registered nurses interviewed were familiar with the referral process to access specialist nursing advice when needed. Regular monitoring forms are implemented where there has been an identified need. The registered nurses have close working relationships with staff from external health care agencies involved in care of the older person including the psychiatry for older people services (i.e. the POPS team). Residents and relatives interviewed believed that care provided was appropriate to meet the needs of residents. Improvement is required to ensure clinical care is documented according to policy |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The service has employed six activity coordinators to cover the three service levels. The activities team is coordinated by a senior activities coordinator. One of the service coordinators has recently completed diversional therapy training. The activities programme is overseen by a lifestyle coordinator who is employed at head office. Care staff participate in providing the individual and group activities programme in all areas. Each resident has a written and implemented activities programme, which is evaluated and reviewed each time their long term plan of care is reviewed. A comprehensive social history is completed on or soon after admission and information gathered is included in the resident’s plan of care. A weekly group programme is available in each area and staff are able to inform residents as to the programme and to encourage them to attend the activity of their choice. A daily record of each resident’s participation in group and individual activities is maintained by the activities staff. The programme includes a wide range of activities to promote physical, cognitive and social wellbeing including visitors and external outings. Residents are able to use two 12-seater (non-hoist capable) vans for outings in the community. Drivers are available to assist or the activities staff can drive. Activities staff are first aid trained. The programme was operating in all areas during the onsite audit. The programme operates from 9 am to 4 pm in the rest home area Monday to Friday. It operates 9.30 to 4.30 pm Monday to Friday in the hospital area and 9 am to 4pm on Saturdays. The activities programme is offered seven days a week in the dementia unit by two activities coordinators from 9 am to 6pm. Residents and relatives interviewed spoke highly of the activities programme.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The clinical manager oversees the review process across all areas to ensure all reviews of residents occur in a timely manner. The clinical manager informs each area manager of all residents who are due for review for the month. Thereafter letters are sent to families informing them of the review date and inviting them to attend or convey any concerns they would like addressed. Registered nurses complete a review of all residents at admission and following their initial period of assessment and then develop the long term plan of care. They update each resident’s plan of care as necessary. Each resident is formally reviewed at least three monthly by a GP and six monthly by members of the multidisciplinary team. A record of the review is documented in the clinical record. The resident’s long term care plan is amended to reflect any changes. Care plans are evaluated and reviewed more frequently when clinically indicated.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed in a visible location (expiry date 22 December 2015). |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy for infection control describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator/RN uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.Individual infection report forms are completed for all infections. This is kept as part of the residents’ files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator, a position that is currently being shared between the clinical manager and a registered nurse. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly with limited evidence of reporting back to staff in the staff meeting minutes (link to finding 1.2.3.6). A recent norovirus outbreak in the secure dementia unit over the Christmas period reflects controlling the spread of infection to the dementia unit only. The virus was contained within one week. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregivers and nursing staff confirm their understanding of restraints and enablers. The service has seventeen residents with bedrails and/or chair support briefs on the restraint register and one resident using bedrails as an enabler. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Data that is collected each month including (but not limited to) residents’ falls, challenging behaviour, infections, pressure areas, and wounds are collated and compared on a month-by-month basis. Results are analysed and evaluated. The village manager and clinical manager report that this data is then communicated to staff in the full staff meetings and in the RN meetings although meeting minutes do not consistently reflect this finding.  | Missing in the meeting minutes is documented evidence of communicating quality and risk activities and findings with staff. The village manager reports steps were undertaken in December 2014 to ensure that staff meeting minutes consistently reflect quality and risk management information. | Ensure discussions relating to quality and risk are documented in the applicable meeting minutes.180 days |
| Criterion 1.3.12.6Medicine 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 Low | The previous audit identified issues with the standard of documentation which related to the charting of medicines by medical staff and the signing by nursing staff on the administration chart. This audit found that improvements have been made in both areas, however further improvements are identified which relate to the standard of documentation. | The following shortfalls in documentation were identified: (i) the allergy status of 2 of 29 residents receiving dementia services (sample extended) was not recorded; and (ii) 1 of 20 residents (sample extended) receiving hospital services did not have photographic identification (which was corrected on the day of audit).  | Ensure the documentation of medicines management meets policy.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | The previous audit noted that several interventions were not being documented to manage all residents’ needs including medical needs where appropriate. A review of seven clinical records confirmed that further improvement is required to address incomplete documentation. | Care was not documented according to policy in three of the seven clinical records reviewed, which included (1) no documentation of a resident’s weight on admission; (2) initial assessments for one resident not being dated and signed by the assessing staff member; and (3) a physiotherapy intervention specified by a physiotherapist was not documented in the resident’s plan of care (although staff were carrying out the physiotherapist’s treatment order). | Ensure clinical care is documented according to policy.90 days |

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

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

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

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

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| No data to display |

End of the report.