# Kapsan Enterprises 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 The DAA Group 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:** Kapsan Enterprises Limited

**Premises audited:** Chadderton Rest Home

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

**Dates of audit:** Start date: 17 February 2015 End date: 25 February 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:** 21

# 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

Chadderton Rest Home provides rest home level care for up to 23 residents. On the day of audit there were 21 residents. The service is privately owned by a husband and wife team who both work in the business. One is the non-clinical manager and oversees all aspects of the service and the other is a registered nurse who oversees all clinical components of care. Resident and family/whanau interviews confirm they are happy with the services received and that their needs are met.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Services Standards and the provider’s contract with the District Health Board. As not all relevant management information could be obtained on the scheduled day of audit, this was continued on the next available date. The audit process included the review of policies and procedures, observations, and the review of residents’ and staff files. Interviews were conducted with residents, family/whanau, staff and management.

The service has addressed seven of the nine shortfalls from the previous certification audit related to resident information, gaining written consent, advance directives, medication management and restraint. Although progress has been made, two previous issues related to care planning require further improvement.

This surveillance audit identified three new areas where improvement are required. These relate to frequency of progress notes documentation, self-administration of medication and ensuring medication standing orders meet current requirements.

## 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. |

Staff provide an environment conducive to effective communication. The service promotes open and honest communication with residents, and where appropriate, family/whanau. Communications are now being documented.

Written consent is obtained from residents or their designated contact person at admission. Advance directives were present in residents’ files reviewed, where appropriate. These practices now meet the standards.

Complaints are managed according to policy and procedure. Interviews with residents and family/whanau confirmed their understanding of the procedure which they feel is easy to follow and that any issues raised are dealt with accordingly. At the time of audit there is one outstanding complaint.

## 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. |  | Standards applicable to this service fully attained. |

The organisation’s business and quality planning processes identify how services are planned, coordinated and appropriate to meet resident needs. Resident and family/whanau interviewed confirm all their needs are being met by the service.

Quality and risk management systems included an internal audit process with corrective actions occurring as required. This system is understood and implemented by staff. Data collection related to infection control, health and safety, complaints, incidents and accidents and restraint minimisation are shared with staff, residents and family/whanau as appropriate. This information is used as an opportunity to improve service delivery where required. This information is used in the update of the annual quality planning process.

Policies and procedures are in place and reviewed by the owner/manager regularly. The documents sighted reflect current best practice and legislative requirements to guide staff actions in the delivery of care.

Human resource management processes identified that good practice standards are observed by the provider. This was confirmed in the staff files reviewed. Staff have access to relevant ongoing education and records of attendance are maintained.

The staffing and skill mix policy requirements are implemented to ensure the residents’ care needs are met. The requirements are aligned with the provider’s contract with Auckland District Health Board (ADHB). A staff member with a current first aid certificate is rostered on each duty. A new registered nurse was employed in November 2015 to assist the owner/nurse manager.

## 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 medium or high risk and/or unattained and of low risk. |

The provision of all stages of care is conducted by staff who are appropriately trained and qualified. Services are coordinated in a manner that promote a team approach and continuity in care. Improvements have been made in relation to the content of the care plans. The care plans sighted in the residents’ files were sufficiently detailed and identified the individual resident’s care needs. However, one resident did not have a long term care plan available for staff. Care was not consistently evaluated on at least a six monthly basis to enable regular monitoring of the resident’s progress towards achieving their long term care goals. These areas require improvement. Where progress is different to that expected, the service responds by initiating changes to the care being provided. There is some variation in the frequency of documented entries in some residents’ progress notes and this requires review.

Activities are planned and provided by a diversional therapist to facilitate and maintain the strengths and interests of the residents. Residents expressed enjoyment about the number and variety of activities available to them.

Food and fluids are provided to meet the needs of the residents. The nutritional services take into account the special needs, likes and dislikes of the residents. The menu has been recently reviewed and approved by a registered dietitian.

A safe medication management system was observed to be implemented. At the last audit areas for improvement were identified in relation to medication documentation and processes. These areas have been addressed. However, improvements are required in relation to the process around self-administering of medications and having sufficiently detailed medication standing orders. Caregivers administering medications have been assessed as competent to do so.

## 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. |

The service has a current building warrant of fitness. The building footprint remains unchanged from the previous audit.

## 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. |

The previous area identified for improvement around free access to the property has been addressed. The facility is restraint and enabler free.

## 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. |

Surveillance for residents that develop infections is occurring. The surveillance is appropriate to the service setting. The infection data reviewed had been analysed and reported to staff and management in a timely manner. There have been no outbreaks of infection since the last audit.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 14 | 0 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 4 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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. | FA | The previous audit identified actions were required to ensure written consent and advanced directives are appropriately documented.  At this audit residents’ consent had been obtained for relevant issues during or soon after admission. These are signed by the resident or designated representatives. Staff advise verbal consent is sought from residents daily for a range of issues including showering/hygiene cares, what to wear, and participation in activities programmes. The residents’ right to change their mind or refuse aspects of care was acknowledged by staff. All residents interviewed confirmed that they are ‘given choice’ and that their choices are respected.  Advance directives are sighted in the residents’ files sampled. These are signed by the resident and the general practitioner who has assessed the resident’s competency to do so. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Policy and procedures are implemented by the service to ensure all complaints are documented and the manager is informed. The manager documents all complaints management follow up. Residents and family/whanau confirmed during interview they understand the complaints process and that when an issue occurs it is followed up by the manager.  The service has an up to date complaints register that shows that complaints are followed up in a manner that ensures opportunities for service improvement are put in place when necessary.  The manager confirms that there is only one outstanding complaint at the time of audit. Documentation identified this is being addressed as per policy and meets required timeframes. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | A family communication sheet is present in the residents’ files. This details ongoing communication with the family members either via phone or in person.  The caregivers advise the registered nurse or manager is responsible for communicating with the resident’s family if there are changes in the resident’s health, care required or if there has been an incident/accident. Open disclosure was documented as occurring following adverse events in records reviewed during audit. This now meets the standards.  The service has not required access to interpreting services for the residents to date. All residents are able to communicate/understand English. Staff advised if an interpreter was required this would be organised by the manager. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Chadderton Rest Home has an up to date business plan. This describes how services are offered to meet residents’ needs, the progress made regarding upgrades, and is in line with the organisation’s values and mission statement. The mission, values and scope of the service are detailed and relates to the provision of rest home level care.  The two owners of the business work in the facility. They have operated the business for over 10 years. One has the overall responsibility for services and one is a registered nurse, with a current practising certificate, who oversees clinical aspects of care. The manager stated they are kept informed of all residents’ needs and wants by staff, residents and family/whanau members. This was observed during the audit.  Both managers attend regular education related to their roles. They have recently employed a RN to assist with clinical care management.  Residents and family/whanau interviewed stated they are happy with the services provided and that all their needs are met. |
| 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. | FA | Documented quality and risk planning was sighted. Staff acknowledge their understanding of internal audit processes during interviews and confirmed corrective actions are shared at staff meetings and followed up by the manager. Any deficits to service delivery are clearly documented and corrective actions are shown with completion dates signed off by the manager. This was confirmed in meeting minutes sighted.  Staff meeting minutes reviewed confirmed that all data reporting is shared for key components of service delivery, such as complaints, incidents and accidents, infection control, health and safety (which included hazard reporting), internal audits and restraint. Staff meetings are chaired by the manager.  The service has a system in place to measure ongoing improvements against the documented business as part of the quality planning process.  Policies and procedures are available to guide staff practice. The manager has an electronic copy of the current version of policies and updates these as required at least two yearly. The service has a document control system in place to ensure obsolete documents are filed electronically and new versions of policy and procedures are alerted to staff.  Residents’ meetings have been regularly held. Minutes sighted reflect a high level of satisfaction with the services provided including the activities programme and food services.  Staff are required to report any hazards. These were sighted in the maintenance folder and are transferred to the hazard register if they are not eliminated. A hazard register was available that detailed a range of hazards related to the facility/environment as well as resident care and the strategies which have been put in place to manage the hazards safely.  The risk register sighted identifies actual and potential risks for all aspects of care services, the external environment, cleaning and laundry and the kitchen. A risk management plan is in place. Organisational risks are categorised and documented with mitigation strategies. |
| 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 | There is an incident and accident reporting policy implemented by staff. Incidents and accidents are documented on specific forms and family/whanau notified accordingly. This was confirmed during resident and family/whanau interviews. Any necessary follow up was documented on the form and in the resident’s notes.  Incidents and accidents are trended against previously collected data and this information is shared at staff meetings as confirmed in minutes sighted. Staff reported their understanding of the incident and accident reporting system and confirmed incidents and accidents are discussed at staff meetings.  The manager was able to detail the type of events that are required to be reported as an essential notification and to whom the notifications are to be made to. There have been no events requiring this level of reporting since the last audit. |
| 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 | A part time registered nurse (RN) has been employed to assist the current owner RN. Current annual practising certificates (APCs) were sighted for both RNs, the general practitioner (GP), and three pharmacists.  The manager discussed the recruitment practice and this aligns with current accepted standards. For example, the cook who has been appointed since the last audit, holds unit standards related to food safety. Recruitment practices were verified in the five staff files reviewed. Current performance appraisals were sighted.  Staff interviewed described the orientation programme provide. This was relevant to their role and responsibility. Staff have access to ongoing education and attendance records are maintained. The diversional therapist had completed their qualifications for this role over the past two years. The education topics are planned to ensure the requirements of the provider’s contract are met. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy details staffing requirements and this meets contractual requirements. The roster sighted identifies there is at least one caregiver on duty at all times. There is a RN on duty three days a week for eight hours and on-call 24 hours a day, seven days a week. There are dedicated activities, cleaning and kitchen staff.  Residents and family/whanau interviewed confirmed they received timely and appropriate care from all staff. A staff member with a current first aid certificate is rostered on duty each shift. This was verified by review of the roster and staff training records. The manager has an electronic record of when staff first aid certificates are due. |
| 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 | The previous audit identified actions were required in order to meet the standards in relation to medication management practices and documentation. These have all been addressed. Allergies were documented and medication reconciliation has occurred. All the medicine charts sighted had prescriptions that now comply with legislation and aged care best practice guidelines.  A resident’s blood glucose levels were not consistently being documented prior to the evening dose of insulin being administered.  The standing orders that are in use are not sufficiently detailed and do not include dose limits and contraindications.  Medication competencies were sighted for four caregivers. The two RNs advised they have both recently completed medication competencies in another health service.  The caregiver confirmed that there was one resident in the rest home who self-administers a medicine. The service’s policies, procedures and self-administration guidelines were not followed for this resident. |
| 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. | FA | The food services are provided by an employee who holds a qualification in catering and who has completed appropriate training in food safely.  A four weekly menu is in use. The main meal is provided at lunch time. The menu has been reviewed by a dietitian in November 2014 and is suitable for the older person living in long term care.  Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. Individual residents’ food and beverage needs/preferences are identified at admission, updated and communicated to the kitchen staff.  The residents and families reported satisfaction with the majority of meals and fluids provided and that the quantity of food provided was sufficient. Staff were sighted to provide individualised meals to the residents during audit and assist the resident as required with their meals. Staff were observed to be regularly offering residents beverages in between meals. There is at least three days of dried foods available for use in emergency.  All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. A new dishwasher has been ordered. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | The previous audit identified actions were required to ensure care plans are sufficiently detailed to guide care. At this audit the long term care plans of four residents were sufficiently detailed to describe the care required for individual residents on a day to day basis. However, one resident did not have a long term care plan available to staff to guide service provision.  Short term care plans (problem lists) have been developed when the residents have a short term care need. The short term care plans detailed what care was required to be provided to the resident and the timeframes, where this was appropriate. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The provision of services and interventions are consistent with, and contributed to, meeting the residents' assessed needs and desired outcomes. The care provided is individualised, aimed at optimising the resident’s independence/functioning and promotes quality of life for the residents.  Where applicable, residents have been seen by the GP and external referrals have been made in a timely manner to medical specialist services/allied health staff. Staff were observed contacting the GP during the audit in response to the changing needs of a resident.  All residents and the family members interviewed reported being satisfied with the care provided by staff. |
| 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. | FA | The activities programme is co-ordinated by a qualified diversional therapist.  Individualised resident assessments are undertaken as part of the admission process to identify the resident’s likes, dislikes, preferences and functional abilities and individual activities plans are developed. These are used to develop a rest home activities plan that is meaningful to the residents. There are planned activities occurring five days a week. A monthly calendar is developed and displayed for residents/family information. The activities programme reviewed included celebrating residents’ birthdays, special days (eg, Waitangi Day and Valentine’s Day), religious activities, cultural activities, arts and crafts, games and outings. Participation in activities is voluntary. The residents interviewed expressed enjoyment of the activities available and active participation in the activities programme was observed during audit. Records of attendance were being maintained. Detailed evaluations of residents’ participation in the activities programme have been completed on at least a six monthly basis in the files sampled. Some individual activities also occurs with residents. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | The previous audit identified actions were required to ensure evaluations are sufficiently detailed. At this audit evaluations of care were conducted against the goals in the long term care plan at least six monthly in only two of the four applicable residents’ files reviewed.  Evaluations of residents’ progress in meeting the requirements of the short term care plans are well documented and completed in a timely manner.  Falls and pressure area risk assessments were not consistently undertaken as part of the care plan evaluation process. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service maintains all checks related to building warrant of fitness requirements. The current warrant of fitness was issued 24 June 2014. There have been no changes to building footprint since the previous audit. |
| 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 | Surveillance for residents who develop infections is occurring and is appropriate for a rest home.  The number and type of infections are reported monthly. The table and graphs are displayed on the noticeboard in the main corridor where it can be sighted by staff, residents and family members. The surveillance data was sighted for the period January 2014 to January 2015 inclusive. Overall the rate of infections is very low.  Staff interviewed advised when a resident was suspected of having an infection this is communicated to the RN and the manager and also to oncoming staff via the shift handover. The results of the surveillance programme were also discussed at the regular staff meetings. This is verified in the staff meeting minutes sighted.  Staff and the RN responsible for infection prevention and control activities advises there have been no outbreaks of infection since the last audit.  Staff interviewed showed good awareness of the signs and symptoms of infection as well as infection activities. This included ensuring residents stayed appropriately hydrated. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has no enablers or restraint in use. This is confirmed in the restraint register and in staff meeting minutes sighted. Policy identifies that enablers shall be voluntary and the least restrictive option to keep residents safe. Staff verbalised their knowledge and understanding of enabler and restraint use when interviewed.  The previous audit identified an area for improvement related to residents being able to leave the premises independently. This has been fully addressed by the service. There is an electronic gate which accesses the main road. Residents’ use of the gate was discussed at the residents’ meeting in February as confirmed in minutes sighted. The gate has a numbered key pad to open and the numbers are clearly displayed for all residents to use. Residents were seen using the gate to exit the premises as they wished during audit. |

# 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 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The majority of medications are supplied by the pharmacy in a pre-packed administration system. The medications that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medications are checked by a staff member against the resident’s medication records on delivery and medications are stored securely. The key to the medication cupboard and medication trolley is carried by staff. The medication records for residents are pharmacy generated. Each contains a photo of the resident. Allergies are documented and medication reconciliation has occurred. All the medicine charts sighted had prescriptions that now comply with legislation and aged care best practice guidelines. Each medicine is individually signed by the GP and has the required level of documentation to allow safe administration of the medicines. The prescriptions reviewed were legible, recorded the name, dose, route, strength and times for administration. The medicine charts recorded the regular, short course and ‘as required’ pro-re-nata (PRN) medicines for each resident. All medication orders have been signed and dated by the GP on commencing and also when discontinued. Medications have been signed as administered for the residents. Three monthly reviews of medicines were recorded on the medicine chart by the GP.  The lunchtime medication round was observed during audit and safe medicine administration was observed. The caregiver verified the residents’ identity, reviewed the allergy related information and administered the medication directly to the resident and waited until the medication had been consumed. The caregiver then signed that the mediations had been administered.  Blood glucose levels have been monitored for residents where this is a component of the care plan. However, the blood glucose level has not been documented in a resident file sampled (either on the BGL/insulin form, the medication administration form or the progress notes) on three evenings in the last two weeks prior to insulin being administered.  There are no controlled drugs in use.  Standing orders are in use. The copy of standing orders that is signed by the GP does not detail maximum dose limits, and contraindications. A more updated version of the standing order was present in the medication folder which includes this information. However, this has not been signed by the GP and is not currently in use. Staff advise standing orders are not commonly used as pro re nata (PRN) medications are prescribed for individual residents by the GP. | The version of standing orders in use is not the current version that details the contraindications and dose limits.  A resident’s blood glucose levels are not consistently documented prior to the administration of the evening dose of insulin. | Ensure the standing orders are sufficiently detailed to meet current accepted practice and that these are reviewed and signed by the prescriber on at least an annual basis.  Ensure blood glucose levels are consistently checked and documented prior to administration of insulin.  180 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | A policy is in place detailing the process to be undertaken prior to a resident self-administering any medication. The policy includes that a resident assessment is to be conducted by the GP or RN at least a three monthly basis and then reviewed on a weekly basis. The self-administration of medication is to be documented in the care plan and weekly reviews also noted in the progress notes. One resident is currently self-administering a medication. There are no records available to demonstrate that the required assessments and reviews have been undertaken. The resident’s care plan does not include that the resident is self-administering a medication. | Records are not available to demonstrate that a resident who is self-administering a medication has had the required assessments and reviews conducted. The residents care plan does not include this information. | Implement the organisation’s policy and maintain the required records when residents self-administer medications.  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 Low | Assessments are conducted including using recognised assessment tools including for pain, falls and pressure areas. However, these were not current in two of the files reviewed (refer to 1.3.8.2).  The care plans include the physical, psycho-social, spiritual and cultural needs of the residents. The service uses a standardised long term care plan which has been individualised to the resident’s needs. The long term care plans sighted identified the resident’s needs/goals and the staff interventions required. One resident who has been in the rest home for over nine months did not have a long term care plan in the file. The staff interviewed confirmed a long term care plan was not available to them as at the time of audit (refer 1.3.5.2). The long term care plans sighted had not been evaluated at least on a six monthly basis as required by the provider’s contract with the Auckland District Health Board for two of the four residents whose records were reviewed.  Short term care plans were documented on a problem list and this detailed the problem/issue and required interventions. The short term care plans were being regularly evaluated to assess if the interventions have been successful in meeting the resident’s needs.  Caregivers document on a shift by shift basis (on the ‘daily care monitoring sheet’) a summary of how each resident’s hygiene, fluid and nutrition, elimination and behaviour has been. Progress notes are documented on a daily or twice daily basis for some residents whose file was reviewed. The resident audited in some detail using tracer methodology has entries in the progress notes at between one and up to 23 days interval and frequently between nine and 11 days. Staff advise progress notes are normally only documented when there is a change from normal or there is an aspect of care to be communicated.  Tracer: The required assessments were documented and recently reviewed. The care plan detailed the resident’s current needs and progress towards achieving the resident’s goals. Progress notes were written infrequently. A daily care summary record was being maintained by the caregivers. The GP has referred the resident to a specialist’s service. Interventions and follow-up care was provided in a timely manner and detailed in a short term care plan. The resident participates in the activities programme which includes activities to meet their interests and abilities. Evaluations are detailed. The resident is weighed at least monthly and variations in weight noted and followed up. The resident was interviewed and expressed satisfaction with the care being provided. Care staff interviewed had a good understanding of the resident’s care plan and interventions required. | Entries in one resident’s progress notes is infrequent. The entries from 10 October 2014 to the date of audit ranged between one and 23 days interval. | Ensure progress notes are consistently documented in residents’ files in a timely manner.  180 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | A total of five residents’ files were reviewed during the audit. Long term care plans were sighted in four of the residents’ files. The care plans were individualised and are now sufficiently detailed to guide staff on the provision of care. This included (but was not limited to) mobility, activities of daily living, elimination needs, dietary needs, socialisation, management of behaviours, and on the care required for specific medications/health issues. One resident who is self-administering a medication did not have this detailed in their care plan as required by the organisation’s policy (refer to 1.3.12.5).  One resident who has been in the rest home for over nine months did not have a long term care plan (LTCP) in the resident’s file. The staff interviewed confirmed a LTCP plan was not available to them at the time of audit. An initial care plan developed on the day of admission was present in the file. The staff were able to describe what care the resident required on a day to day basis. This included mobility needs, resident specific strategies for de-escalation of challenging behaviours, and dietary needs. Subsequently the RN identified a LTCP had been developed however was only available electronically on the computer.  Short term care plans (problem lists) were developed when the resident had a short term care need to detail what care is required. Examples sighted included when the resident had a wound, an infection, weight loss or dietary issues. A staff member was observed providing wound care in accordance with the short term care plan. | One resident did not have a long term care plan available for staff to guide the provision of care. | Ensure a long term care plan is available to care staff for every resident to guide the provision of care.  180 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Evaluations of care are conducted against the goals in the long term care plan on at least a six monthly in two of the four residents’ files reviewed. The remaining two residents had long term care plans developed in June 2014 which have yet to be evaluated. One resident had a new long term care plan developed in the last month and frequent evaluations have already occurred to date. Where evaluations have been done these were resident focused, indicated the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes.  Assessments, including falls risk and pressure area risk are undertaken. These have been reviewed at least six monthly in some of the resident files reviewed. However, one resident whose file was reviewed, has a documented falls and pressure area risk assessment last completed in early 2012. Another resident had these assessments most recently reviewed over 12 months ago.  Short term care plans have been developed when the needs of the resident have temporarily changed. The progress to meet the short term care needs have been evaluated in a timely manner and closed when no longer applicable.  Resident’ weights are evaluated at least monthly in all files sampled. This was documented and variances identified and followed up.  The residents and family/whanau interviewed reported satisfaction with the care provided. | Evaluation of resident’s progress towards achieving the resident’s goals (as identified in the long term care plan) is not consistently occurring on at least a six monthly basis for all residents.  Evaluation of falls and pressure area risks are not consistently occurring in a timely manner. | Ensure evaluations of residents’ progress towards achieving the goals in the long term care plan are conducted on at least a six monthly basis or sooner where indicated.  Ensure falls and pressure area risk assessments are evaluated and updated in a timely manner.  180 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.