# Thorrington Village - Santa Maria

## Introduction

This report records the results of a Provisional 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:** Thorrington Village Limited

**Premises audited:** Santa Maria

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

**Dates of audit:** Start date: 4 May 2015 End date: 5 May 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:** 46

# 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

Santa Maria can provide care for up to 58 residents, occupancy on the first day of the audit was 46 . The service provider is certified to provide rest home and rest home dementia level care. The facility is currently operated by Santa Maria Holdings Ltd.

This provisional audit was undertaken to establish the extent to which the existing provider conformed to the requirements of the Health and Disability Services Standards and the District Health Board (DHB) funding contract prior to a change in ownership. This audit also established how well prepared the prospective provider is to provide a health and disability service. A representative for the prospective provider was interviewed during to this audit and advised they have been the general manager of the residential care facility since 2003. The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and medical officers.

The prospective owner currently owns another residential care facility and is proposing to assume responsibility for the provision of services at Santa Maria from 2 June 2015. There is a transition plan around the purchase. The prospective owner advised there will be no changes to the running of the facility to minimize disruption and view the operation over time, compare systems with their other facility over time to determine what best practice for both sites is. A new facility manager will be appointed for the overall operational running of Santa Maria, and will report to the prospective owner’s general manager.

Residents and family members interviewed provided positive feedback on the care provided.

The following improvements are required related to: complaint management; quality systems; staff education; staffing; staff orientation; residents’ meetings; policies and procedures; management education/ training; appointment of a new facility manager; adverse events; informed consent; risk assessments; medication management; activities care plans; evaluation of care; staff competencies; food fridge temperatures; short term care plans; and long term care plans.

## 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. |

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the code) and the Nationwide Health and Disability Advocacy Service, is brought to the attention of residents and their families on admission to the facility.

Residents and family members interviewed confirmed that: their rights were met; staff were respectful of their needs and they had an understanding of their rights and the facility’s processes if these were not met.

## Organisational management

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

Santa Maria Holdings Ltd is the current governing body and is responsible for the services provided at Santa Maria. Systems are in place for monitoring the services provided at the facility. A business plan for the existing provider and transition plan for the prospective provider were reviewed.

Thorrington Village Ltd, is proposing to purchase the facility and assume responsibility for the provision of services. This provider is currently involved in the aged care sector. The general manager was interviewed and has been in this position since 2003. An organisational structure for the prospective provider was reviewed and demonstrated the linkages between Thorrington and Santa Maria.

There is an internal audit programme in place.

There are policies and procedures on human resources management and the validation of current annual practicing certificates for personnel who require them to practise was occurring. In-service education is provided for staff and staff are supported to complete the New Zealand Qualifications Authority Unit Standards.

There is a documented rationale for determining staffing levels and skill. The minimum number of staff was provided during the night shift and consists of three caregivers.

Resident information is entered into a register in an accurate and timely manner. Residents' files were integrated and documentation was legible with the name and designation of the person making the entry identifiable.

## Continuum of service delivery

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

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The clinical nurse manager is responsible for assessment, care planning and evaluation of care, with input from residents and family. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. An improvement is required around completing 24 hour activities care plans for residents in the dementia unit.

There is a secure medication system at the facility.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were 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. |

Santa Maria has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner’s room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are available with suitable pathways, seating and shade provided. Smoking is only permitted in designated external areas.

## Restraint minimisation and safe practice

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

The restraint policy, procedures and the definitions of restraint and enabler were congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were no residents using restraint or enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour had been provided.

## Infection prevention and control

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

The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. Infection control practices are part of an orientation programme and there is an on-going infection control education available for staff. Infection control is a standard agenda item at facility’s meetings. Staff interviews confirmed staff were familiar with infection control measures at the facility.

The infection control surveillance data was sampled through resident records and collated infection reports. The information sampled confirmed that the surveillance programme was appropriate for the size and complexity of the services provided.

## 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 | 30 | 0 | 7 | 8 | 0 | 0 |
| **Criteria** | 0 | 75 | 0 | 9 | 9 | 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 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the in-service education programme. The education on the Code was provided in 2014 by a staff member from the advocacy service. Interviews with staff confirmed their understanding of the Code and implementing it into their everyday practice.  The information pack provided to residents on entry includes how to make a complaint, code of rights and advocacy information.  The auditors noted respectful attitudes towards residents on the days of the audit. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Low | There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. The policy and procedure includes guidelines for consent for resuscitation/advance directives. The resident files identified that informed consent was inconsistently recorded. In interviews, staff confirmed that residents were aware of treatment and interventions planned for them, and the resident and/or significant others were included in the planning of care. Interviews with the RN confirmed their understanding of informed consent processes.  The residents and family are provided with information regarding informed consent on admission to the facility. The registered nurse / clinical nurse manager discusses the informed consent processes with residents and their families/whānau during the admission process. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is provided to residents and families on admission. Staff training on the role of advocacy services was included in training on The Code of Health and Disability Consumers’ Rights – last provided for staff in 2014.  Discussions with family and residents identified that the service provided opportunities for the family/EPOA to be involved in decisions and they stated that they have been informed about advocacy services. The resident files included information on resident’s family/whanau and chosen social networks. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources  Consumers are able to maintain links with their family/whānau and their community. | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families interviewed confirmed they could visit at any time and were always made to feel welcome.  Residents were encouraged to be involved in community activities and to maintain family and friends networks. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Low | The complaints policy and procedure is in line with the Code and includes timeframes for responding to a complaint.  A complaints register was in place, however did not record all complaints. Three complaints reviewed indicated that the complaints were investigated promptly with the issues resolved in a timely manner. Residents and family members interviewed stated that they would feel comfortable complaining.  The managing director stated that there had been no complaints with the Health and Disability Commission since the previous audit or with other authorities. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The Code, including the complaints process is discussed with residents and their family on admission. Residents and family interviews confirmed their rights were being upheld by the service. Information regarding the Health and Disability Advocacy Service was available. Residents and family members were able to describe their rights and advocacy services. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has policies and procedures that are align with the requirements of the Privacy Act and Health Information Privacy Code. Residents are addressed by their preferred name and this was documented in files reviewed.  A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner. The care plans did not record needs related to sexuality and intimacy (refer to 1.3.5.2).  The residents’ own personal belongings were used to decorate their rooms. There were instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement. Discussions of a private nature are held in the resident’s room and there are areas in the facility which could be used for private discussions. Caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families interviewed confirm the residents’ privacy was respected.  There was no recorded evidence on the 2014 and 2015 in-service education programme of training on abuse and neglect (link # 1.2.7.5).  Resident files reviewed identified that cultural and /or spiritual values and individual preferences were identified.  There are church services at the facility. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | There is a Maori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents to practise their own beliefs are acknowledged in the Maori health plan. There were no Maori residents living at the facility during the audit.  Staff reported that specific cultural needs were identified in the residents’ care plans and this was sighted in files reviewed. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | There is a culture of choice with the resident determining when cares occur, times for meals and choices in activities. Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident’s cultural values and beliefs (link # 1.3.4.2). This information was used to develop a care plan. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | There are policies, procedures and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation (link # 1.1.8.1). Interviews with staff confirmed their understanding of professional boundaries. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | PA Low | There are policies and procedures that align with the health and disability services standards and the DHB contract. There is a quality framework that supports an internal audit programme. Residents and families interviewed expressed satisfaction with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Accident/incidents, the complaints procedure and the open disclosure procedure alert the RN and management to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. Family are informed if the resident had an incident, accident, had a change in health status, as evidenced in completed accident/incident forms. Family contact was recorded in residents’ files. Interviews with family members confirmed they were kept informed. Resident meetings are not held at the facility.  Interpreter services are available, if required. There were no residents requiring interpreting services. Residents signed an admission agreement on entry to the service. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | Santa Maria is certified to provide rest home and rest home dementia level care. On day one of this audit there were 11 residents assessed as requiring rest home dementia level care, 26 residents requiring rest home level care in the rest home and nine residents requiring rest home level of care in the studio apartments. The total number of beds at the facility is 58: 15 rest home dementia beds, 30 rest home beds in the rest home and 13 rest home beds in studio apartments.  The managing director / owner is the current service provider and governing body. The current business plan for Santa Maria was reviewed. Systems are in place for monitoring the services provided at Santa Maria. Reporting includes reporting on quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes, and clinical indicators were sighted during this audit. The Santa Maria documented scope, direction; goals were reviewed along with a written quality and risk management plan/policy. The service philosophy is in an understandable form and is available to residents and their family.  Thorrington Village is proposing to purchase the facility and assume responsibility for the provision of services. The general manager (GM) for Archer was interviewed. He is an experienced residential care manager and has been in this role since 2003. The general manager has management qualifications and has been in general management positions for over 20 years  The general manager for the prospective purchaser provided a transition plan with timelines and an organisational structure. The general manager for Thorrington reported they have advised HealthCERT of the proposed sale/ purchase of the facility.  The facility is currently being managed by two managers, the managing director / owner and the operations manager. The clinical nurse manager /RN works full time, is on call after hours and oversees the clinical services at the facility. The clinical nurse manager was employed in May 2014. Archer Memorial Baptist Home Trust has established a new company, owned 100% by them, called ‘Thorrington Village Ltd’ which will be the legal entity name and trading name. Archer has appointed a new Facility Manager who will have full support team comprising of Archer’s General Manager, Nurse Manager and Quality Manager. Transition plan for the prospective provider was reviewed and included a list of tasks to be undertaken and timeframes identified. The GM for the perspective provider advised that after purchase, the existing policies and procedures and quality and risk management systems will be reviewed with systems the prospective provider is using in their other facility.  Current management have not completed any education/ training in managing a rest home in 2014 and 2015. |
| Standard 1.2.2: Service Management  The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. | FA | There are systems in place to ensure the day-to-day operation of the service continues should the managing director or the operations manager be absent. The clinical nurse manager (CNM) advised they fill in during temporary absence of the managers. The CNM will also oversee with change of ownership. The clinical nurse manager is on call after hours.  Services provided meet the specific needs of the resident group within the facility. Job description and interview of the CNM confirmed their responsibility and authority for their role. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Moderate | The general manager for Thorrington advised following purchase of Santa Maria: policies, procedures and quality and risk management systems that are currently being used at the facility will be reviewed with systems the prospective provider is using in their other facility.  Relevant standards and legislative requirements are identified and are included in the policies and procedures manuals. Policies and procedures reflect current accepted good practice. Policies / procedures are available with systems in place for reviewing and updating the policies and procedures regularly. Staff report policies and procedures are available in the staff room (link #1.1.8.1).  Internal audit schedules and completed audits for 2014 and 2015 were reviewed.  Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. Facility’s meetings are held monthly and minutes were reviewed. Meeting minutes were reviewed and provide evidence of discussion and reporting on accident/ incidents; hazards; health and safety objectives and maintenance. Staff report during interviews that copies of meeting minutes are available for them to review. Accident/incident, medication error and infection control surveillance monthly summaries were reviewed and included (but not limited to) reporting of numbers of falls, skin tears, other injury, infections and medication errors. The analysis and evaluation of these summaries was inconsistently completed.  The health and safety management systems manual, documents health and safety policies. Risks are identified and there is a hazard register, which is reviewed that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | Staff were documenting adverse, unplanned or untoward events on an accident/incident form. The clinical nurse manager (CNM) / RN is advised of all adverse events when they are on duty. The RN undertakes an assessment of the resident following adverse events when on duty. If they are off duty and a resident sustains an injury, the CNM /RN is contacted. The CNM /RN reviews all accident/incident forms.  Resident files reviewed provided documented evidence of communication with family and GP on the accident/incident form.  Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Staff also confirmed they are completing accident / incident forms for adverse events. Policy and procedures comply with essential notification reporting (e.g. health and safety, human resources, infection control). |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions. These were reviewed on staff files. Copies of annual practising certificates were reviewed for all staff that require them to practice and are current.  There is an in-service education programme. The education planners for 2014 and 2015 and attendance records for education session were reviewed and provided evidence on-going education was provided. Competency assessments were not available or completed where required.  Staff are supported to complete the New Zealand Qualifications Authority approved aged care education modules. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.  An orientation/induction programme is available. Orientation for staff covers the essential components of the service provided. |
| 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 a documented rationale in place for determining service provider levels and skill mixes. The CNM commenced their role at the facility in May 2014. Second RN was employed in November 2014 and resigned in April 2015. The CNM is the only RN till appointment of a second RN occurs mid - May 2015. The CNM / RN works Monday to Friday and is available after hours for clinical support and advice. The minimum amount of staff on duty is during the night and consists of three caregivers.  Care staff interviewed reported there is adequate care staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift.  Residents and family interviewed reported staff provide them with adequate care. In interview, the GPs they were kept informed of changes in residents’ conditions and treatment plans were followed in timely manner.  The general manager for Thorrington advised they are proposing to employ a new facility manager, who will report to the Archer general manager. The clinical nurse manager will report to the facility manager. The proposed new owner advised there will be no immediate changes to the roster and staff cover at the facility, apart from the appointment of a new facility manager and the second RN. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Resident information is entered in an accurate and timely manner into a register on the day of admission. Resident files were integrated and current, test/investigation/assessment information was located in residents' files. Approved abbreviations are listed. Resident files reviewed provided evidence that an entry into the residents’ clinical record includes the time of entry, the date and entries are dated and legible.  Residents' information is stored in staff areas and held securely and not on public display. Clinical notes were current and accessible to all clinical staff. The resident's national health index (NHI) number, name, date of birth and GP are used as the unique identifier.  Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information. Historical records are accessible. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents are assessed prior to entry to the service by the needs assessment team and an initial assessment is completed on admission. The service has specific information available for residents/families/whānau at entry and it includes associated information such as the Health and Disability Code of Rights, advocacy and complaints procedure. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The transfer /discharge/exit procedures include a transfer/discharge form and the completed form is placed on file. The service stated that a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. |
| 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 service uses individualised medication blister packs which are checked in on delivery to the facility. Caregivers were observed administering medications correctly in the rest home and dementia unit. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. Shortfalls have been identified around medication competencies, documentation and management.  Medications and associated documentation are stored safely and securely. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 14 medication charts reviewed. Medication fridge temperatures are monitored.  There is a self-administering resident’s policy and procedures in place. There were no residents who self-administered medications on audit days. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | All meals at the facility are prepared and cooked on site. There is a four weekly winter and summer menu, which had been reviewed by a dietitian. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunch time meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen.  Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident surveys allow for the opportunity for resident feedback on the meals and food services generally (link1.2.3.8). Residents and family members interviewed indicated satisfaction with the food service. Food and snacks are available 24 hours a day for all residents. |
| Standard 1.3.2: Declining Referral/Entry To Services  Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate. | FA | The reason for declining service entry to residents to the service would be recorded, and when this has occurred, the service stated it had communicated to the resident/family/whānau and the appropriate referrer. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | PA Moderate | All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission, which forms the basis of resident goals and objectives. Assessments are completed prior to completing the initial care plan to ensure that all resident needs are met. The clinical nurse manager (RN) has commenced InterRAI training. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Resident files reviewed identified that family were involved in the care plan development and on-going care needs of the resident. Family members interviewed stated they were kept informed and were happy with the care provided. Shortfalls were identified around interventions |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents’ files reviewed evidenced the long term care plans were completed, however were not all current (link# 1.3.5.2 and 1.3.8.3).  In interviews, staff and relatives confirmed involvement of families in the care planning process. Dressing supplies were available and a treatment room was stocked for use. Continence products were available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice was available as needed and this could be described. Wound assessment and wound management plans were in place for one heel pressure area, one chronic leg ulcer and four skin tears. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate | The activities co-ordinator plans and implements an activities programme over five days each week, between the hours of 0900-1630. The programme is planned monthly and residents receive a personal copy of the planned monthly activities. Activities planned for the days of audit were displayed on notice boards around the facility. A recreational plan is developed for each individual resident based on assessed recreational needs. The activities co-ordinator undertakes activities in both the rest home and dementia unit providing 30 minute time timeframe, three times a day in each unit. Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings have not been provided (link # 1.1.9.1). Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. Overall dementia unit files reviewed did not evidence activities/cares across 24 hour activities plans. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Moderate | There is a policy on care planning and includes care plan evaluation timeframes. Family interviews confirmed family were notified of any changes in their relative’s condition and also confirmed their involvement in care plan evaluations. GP interviews confirmed the RN communicates any changes of resident’s condition to them in timely manner. Short term care plans are inconsistently completed for short term problems. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and / or their family/whanau are involved as appropriate when referral to another service occurs |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Product use charts were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. There was no recorded evidence on the staff in-service programme of safe chemical handling training provided in 2014 and 2015 (link # 1.2.7.5). |
| 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 displays a current building warrant of fitness which expires on 1 July 2015. Hot water temperatures are checked, as per monthly schedule. Medical equipment and electrical appliances have been tested and tagged and calibrated. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | All resident rooms in the rest home are single rooms. The dementia unit has five single rooms and five rooms shared by two residents. Consents for room sharing is included and evidenced in the admission agreements. Residents share communal showers and toilets, some rest home residents share a toilet between two rooms. Studio rooms all have a full ensuite bathroom. There were sufficient numbers of resident communal toilets in close proximity to resident rooms and communal areas. Visitor toilet facilities are available. Bathrooms are signed and identifiable and display large vacant/in-use signs. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | The resident rooms are spacious enough to meet the assessed resident needs. Residents were able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient room to allow cares to take place. The bedrooms were personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There is a large lounge and dining room in the dementia unit and separate lounge and dining areas in the rest home. Smaller lounge areas at the end of each wing as well as small seating areas in hallways provide multiple options for residents. The dining rooms are spacious, and located directly off the kitchen/servery area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | The facility monitors the effectiveness and compliance of cleaning and laundry services. There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. Staff have attended infection control education and there was appropriate protective clothing available. Manufacturer’s data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of their room and the facility. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has a fire and emergency procedures manual. The service has an approved fire evacuation scheme. There is a staff member with a first aid certificate on each shift. Fire safety training has been provided. A call bell light over each door alerts staff to the area in which residents require assistance. Visitors and contractors sign in at reception when visiting. Fire drills have been conducted six monthly. Civil defence and first aid resources are available. Sufficient water is stored for emergency use and alternative cooking facilities are available. Emergency lighting is installed. Security checks have been conducted each night by staff. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable. |
| Standard 3.1: Infection control management  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. | FA | The infection control (IC) policy and procedures provide information and resources to inform staff on infection prevention and control (link # 1.1.8.1).  The delegation of infection control matters is documented in policies, along with an infection control nurse’s (ICN) job description. The infection control nurse is the clinical nurse manager/ registered nurse. There was evidence of regular reports on infection related issues and these were communicated to staff and management. The IC programme was reviewed annually (link #1.2.3.6). |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The IC nurse has access to relevant and current information which is appropriate to the size and complexity of the service. The IC is an agenda item at the facility’s meetings, evidenced during review of meeting minutes and interviews with staff. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The IC policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. They are written in a user friendly format and contain appropriate level of information and are readily accessible to all personnel (link # 1.1.8.1). The IC policies and procedures are developed and reviewed regularly by an external consultant. IC policies and procedures identify links to other documentation in the facility. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The service provider's documentation evidenced that infection control education is provided to staff, as part of their orientation and as part of the on-going in-service education programme (link # 1.2.7.4). The IC staff education was provided in 2014 by an infection control expert. The ICN attended an external education in IC.  In interview, the RN advised that clinical staff identify situations where IC education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted.  Some staff files evidenced completed IC competencies (link # 1.2.7.4). |
| 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 | The infection control surveillance data was sampled through resident records, staff interviews and collated infection reports. This information confirmed the type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events. The infection control data is communicated to staff at facility’s meetings.  There is collation of surveillance data, however analysis, causes and trends and corrective actions where required, were not documented (link # 1.2.3.8). Residents’ files evidenced the residents’ who were diagnosed with an infection did not always have a short term care plan (link #1.3.8.3).  In interviews, staff reported they were made aware of any infections of individual residents by way of feedback from the RN, verbal handovers, handover sheets and progress notes. In interview, the RN confirmed there were no outbreaks at the facility in 2014. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the Standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There were no residents using restraint or enablers at the facility on audit days.  The approval process for enabler use will be activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.  In interviews with staff and on the in-service programme there was evidence that education in restraint minimisation and safe practice (RMSP) was provided in 2014, however the attendance records evidenced five staff attended. There was no recorded evidence of staff competencies in restraint (link #1.2.7.5). |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.4  The service is able to demonstrate that written consent is obtained where required. | PA Low | There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. The resident files identified that informed consent was inconsistently recorded. | Two of seven residents’ files reviewed evidenced that written consent had not been obtained. | Provide evidence the informed consent is recorded.  90 days |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | Review of the complaints register was conducted and evidenced three complaints were lodged in 2014 and no complaints recorded in 2015.  The 2014 complaints evidenced timely resolution of complaints, to the satisfaction of the complainants. There was one written complaint on a complaint form that had not been entered onto the register. Review of this complaint evidenced the timeframes had not been followed and there was no documentation of the satisfaction of the complainants of the resolution. Interview with the complainants evidenced the complaint had not been resolved to their satisfaction. Interview with the quality manager confirmed this complaint had not been communicated to them or discussed at quality or staff meetings.  Interview with the managing director confirmed verbal complaints are not recorded on the complaints register. | The complaints register does not record all complaints, timeframes relating to complaints management are not adhered to and complaints are not communicated to staff. | Provide evidence of up-to-date complaints registers that includes all complaints, dates and action taken and these are communicated to all concerned.  90 days |
| Criterion 1.1.8.1  The service provides an environment that encourages good practice, which should include evidence-based practice. | PA Low | New policies and procedures were introduced to the facility in July 2014. Staff education on the new policies was provided in October 2014 and the attendance register records this was attended by 18 staff. Review of the new policy folders evidenced not all staff have signed that they have read and understood the policies. Interview with staff confirmed this has not occurred. | The new policies have not been read by all staff. | Provide evidence the new policies have been read and understood by staff.  90 days |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | There was no recorded evidence of residents’ meeting being conducted at the facility. Interview with staff and management confirmed there were no residents meeting held.  Interview with residents confirmed they were not informed of activities at the facility on regular basis. | Resident meetings are not held at the facility. | Provide evidence the service hold regular residents’ meetings.  90 days |
| Criterion 1.2.1.3  The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services. | PA Low | The managing director and the operations manager’s files could not be reviewed. Management advised they had not completed any related education/ training relating to managing a residential facility in 2014 and 2015.  The proposed new owner confirmed a new facility manager will be appointed for the overall operational running of Santa Maria, and will report to the proposed new owner’s general manager. | Management have not completed any education/ training in managing a rest home in 2014 and 2015 and the new facility manager has not been appointment to manager the facility following the purchase. | Provide evidence management complete the required number of hours in education/ training in managing a rest home and appointment of a new facility manager.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | A resident /family satisfaction survey was completed in January 2014. The resident satisfaction survey had been collated, however had not been analysed and evaluated. The family satisfaction survey had not been collated, analysed or evaluated. There was no recorded evidence both satisfaction survey results were communicated to staff, residents and family. The 2014 infection control surveillance summary evidenced there had been no collation, analysis or evaluation of this data. Management interviews confirmed 2015 satisfaction survey was sent out a month prior to the audit and awaiting the return of questionnaires.  Accident/incident, medication error and infection control surveillance monthly summaries were reviewed and included (but not limited to) reporting of numbers of falls, skin tears, other injury, infections and medication errors. The analysis and evaluation of these summaries was inconsistently completed.  Staff meeting minutes were reviewed and provided evidence of feedback on any analysis of quality improvement data to staff. | The resident and relative satisfaction surveys and monthly quality summaries evidence inconsistency in the results being collated, analysed, evaluated and communicated to all concerned. | Provide documented evidence that quality data is collated, analysed and evaluated and that the results are communicated to all concerned.  180 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | Correction action plans are being developed and recorded for deficits identified following internal audits. Interview with the quality manager confirmed there is a process of completion of audits as per the internal audit programme and documentation of corrective action where shortfalls were identified. The findings and corrective action plans are discussed at quality meetings, however there is evidence the corrective action plans are inconsistently implemented. Quality meeting minutes reviewed recorded deficits following internal audits that were discussed at the quality meetings; however implementation of the corrective action plans has not occurred.  There was evidence the shortfalls identified in satisfaction surveys and accident / incident forms did not have corrective action plans completed. Review of the quality meeting minutes evidenced corrective actions were not developed following deficits raised and there is no evidence in subsequent meeting minutes of the issues identified. | Corrective action plans are inconsistently developed and implemented following deficits identified in internal audits, satisfaction surveys and adverse events. | Provide documented evidence that where areas have been identified as requiring improvement, corrective action plans are being consistently documented, implemented, monitored, evaluated and signed off as having been completed; and the person/s responsible for the corrective action and the timeframe for implementation of the corrective action/s are clearly identified.  90 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Seven adverse events were reviewed. Of the seven adverse events, there were six events of unwitnessed falls of which four were with head injuries. There were no neurological observations conducted for all of the unwitnessed falls with injuries. Adverse events are not being consistently managed to identify and manage risk. The falls resulting with injury requiring specific care and interventions did not have short term care plans completed (link # 1.3.8.3). | (i)There were no neurological observations conducted for all of the unwitnessed falls with head injuries. (ii) Five of the seven adverse events reviewed identified staff were not informed of the adverse event in progress notes. | Provide evidence the adverse events are managed according to policy.  30 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | Three of eight staff files reviewed evidenced the orientation checklists had not been fully completed and verified by the person orientating the new staff member. Interview with the CNM confirmed they have not been involved with orientating new staff. Newly appointed care staff interviews confirmed their orientation was conducted by a senior caregiver with no input from the RN. There was evidence the staff who have been recently employed have not completed competencies such as manual handling, hand hygiene (link # 1.2.7.5). | There is inconsistency in completion of orientation checklists. (Advised this was completed post-audit). | Provide evidence the orientation programme is fully completed by all new staff.  180 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 orientation programme in place (link #1.2.7.4). The service provides in-service education for staff. Staff have completed first aid training and there is a staff member on duty with current first aid. There is inconsistency in staff completing competency assessments. Hand hygiene competencies were inconsistent; there was evidence of five staff that have completed wound competencies and no evidence of manual handling or restraint competencies. The medication competencies do not evidence a written component of assessment. (link # 1.3.12.3).  Interview with the ACE educator and review of a register of staffs’ ACE education training record evidenced not all staff have completed the required dementia training / education or the aged care training as per the ARC contract D17.6c and E4.5f. One senior care giver who works in the dementia unit has completed ACE foundation papers and two ACE dementia related papers, since their employment in 2011. The activities co-ordinator has not completed the ACE foundation papers since their employment over 15 months ago.  The 2014 and 2015 in -service education programme evidenced not all compulsory education has been provided, such as : abuse and neglect; chemical training. | (i) The required competencies for staff have not been conducted consistently. (ii)There is evidence not all staff have completed staff education relating to their positions. (iii) Not all the mandatory education relating to aged care has been provided. (Advised that following the audit all staff competencies have been completed). | Provide evidence of staff education relating to their positions, the required mandatory education relating to aged care and completion of staff competencies.  180 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 Moderate | The medication management system is documented. The service uses individualised medication blister packs which are checked in on delivery to the facility. | Four of fourteen medication charts did not evidence indications for use of as required medications. Progress notes did not include the reasons for or the effectiveness of as required medications, as instructed in the LTCP. The signing sheet completed for one resident did not have the medication name documented on the signing sheet. Eye drops being administered were opened and used for two months. | (i)Ensure ‘indications for use’ are documented; (ii) Ensure the effectiveness of ‘as required’ a medication is documented; (iii) Ensure charts are labelled: (iv) Ensure eye drops are dated on opening and discarded as required  30 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | All staff administering medication are required to have a medication competency assessment undertaken, passed and reviewed annually. | Eight of ten caregivers’ medication competencies are either incomplete or do not meet the required standard. There is no written test as part of the medication administration competency assessment. Six caregivers have insulin administration competencies; however one of the six does not meet the requirements. | (i)Ensure a documented competency is completed to assess medication administration competency is undertaken, passed and reviewed annually for all staff involved in checking and administering medication. (ii) Ensure only staff identified as competent administer medication.  30 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Foods are stored appropriately and pantry stock is rotated to ensure no stock is out of date. Fridge and freezer stock is labelled and dated. Temperatures are taken of meat prior to serving and fridge temperature monitoring is undertaken in the kitchen. | Fridge temperatures are not monitored in the staff room or for the fridge at the residents’ tea/coffee making area. | Ensure all fridges have their temperature monitored.  180 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 | Risk assessments are completed to ensure specific resident focused care is provided. Medical assessments and three monthly medical reviews were documented in all seven residents’ files by a general practitioner (GP). Care plans, risk assessments and evaluations were not all completed/reviewed as per ARC contract. | (i)No risk reassessments had been updated for at least 12 months in two dementia service clinical files reviewed. (The sample was increased by four additional files of which one had current risk assessments). (ii) Long term care plans of two residents with dementia evidenced they had not been updated in 12 months. One of the two residents had been admitted from the rest home and staff continued to use the rest home care plan. (The sample sized was increased by four files and evidenced one current care plan); (iii) one care plan was not completed within 3 weeks. | (i)Risk assessments to be reviewed when care plans are reviewed as well as when a change in health status occurs; (ii) Ensure evaluations are completed within time frames and as resident’s health status changes; (iii) ensure care plans are completed within 3 weeks.  60 days |
| Criterion 1.3.4.2  The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning. | PA Moderate | There was evidence in the residents’ files reviewed of behaviour assessments not being completed for residents exhibiting behaviours that challenge. Assessments are reviewed at least six monthly for rest home and dementia residents, however this is undertaken inconsistently. | Inconsistent risk assessments evidenced in clinical files reviewed. No behaviour assessments were evidenced for residents with behaviours that challenge. | Ensure all risk assessments are completed, including behaviour assessments for residents exhibiting challenging behaviours.  30 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 Moderate | The facility has four couples in residence and the long term care plans (LTCP) in three of four resident files reviewed where the resident had a spouse in the facility did not identify this. There was no evidence the residents’ LTCP had a section for sexuality and intimacy needs. The family members interviewed reported that they were happy with the care provided and the communication they received. | Five of seven long term care plans (LTCP) did not always reflect the resident’s current needs or include interventions to support identified issues. | Ensure residents long term care plans reflect the resident’s current needs and the required interventions relating to those needs.  30 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | Activities assessments are completed prior to activities care plans being completed. Monthly progress summaries and attendance registers are completed for all residents. | Five of six files reviewed from the dementia unit (noting the sample was increased), did not evidence activities/cares across 24 hour activities plans. | Ensure all residents in the dementia unit have a 24 hour activities plan completed on admission to guide care staff in the residents’ likes, preferences and routine.  60 days |
| Criterion 1.3.8.3  Where progress is different from expected, the service responds by initiating changes to the service delivery plan. | PA Moderate | Short term care plans were sighted to be utilised for some short term problems. | Short term care plans are inconsistently completed for short term problems and when completed they are not signed off as resolved. | Ensure short term care plans are developed for all short term problems and these are reviewed and signed off when the problem is resolved. If the problem becomes an on-going one and does not meet the short term goals it should be transferred to the LTCP.  60 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.

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

End of the report.