

# Elsdon Enterprises Limited - Annaliese Haven

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Elsdon Enterprises Limited
<b>Premises audited:</b>	Annaliese Haven Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 27 May 2015    End date: 27 May 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	50

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Annaliese Haven provides rest home and dementia level care for up to 63 residents. The manager of the service is a registered nurse, who is supported by a clinical manager (registered nurse) and care staff. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of a sample of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed four of eleven shortfalls from the previous certification audit around documenting staff designation, conducting assessments, serving practices at meal times, and calibration of equipment.

Further improvements continue to be required around corrective action planning, aspects of training, evidence of registered nurse input into progress notes, aspects of care planning and interventions, and aspects of medication management and staff competencies.

This surveillance audit identified that further improvements are also required in relation to open disclosure; completing internal audits; management of accidents and incidents; staff orientation; timeliness of conducting evaluations; and food and nutrition services.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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The rights of the resident and/or their family to make a complaint is understood, and upheld by the service. Complaints reviewed have been managed appropriately.

## 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.
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Services are planned, coordinated, and are appropriate to the needs of the residents. A manager (registered nurse) and clinical manager (registered nurse) are responsible for the day-to-day operations of the facility. Goals are documented for the service. A quality and risk management programme is in place, which includes health and safety processes. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with facility policy. Staffing is adequate to meet the needs of the residents. Registered nursing cover is provided Monday to Saturday and after hours with on-call cover.

## 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.
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Registered nurses are responsible for care planning processes. Care planning demonstrates residents and their family participate in care planning processes. Planned activities are appropriate to the residents' interests. Residents interviewed confirm their satisfaction with the programme. The activities programme reviewed supports the interests, needs and strengths of residents. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly and there is a separate programme for the rest home and the dementia unit. Staff responsible for medicine management have attended in-service education for medication management. The provider implements systems to safely manage medication administration, review, storage and disposal. All food is cooked on site. Residents and relatives interviewed confirmed satisfaction with food services. Systems for food procurement, storage and preparation are effective. Food is served at suitable temperatures.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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A current building warrant of fitness is posted in a visible location. Medical equipment has been calibrated by an external company.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Policies and procedures are in place for restraint and enabler use. There were no residents who required enablers or restraints during the audit.

## 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.
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The infection prevention and control programme aims to prevent the spread of infection and reduce the risks to residents, staff and visitors. The surveillance programme is appropriate for the size and nature of the services provided. Monthly surveillance data and audits is recorded, collated and reported back to staff. Results of surveillance are acted upon, evaluated and reported to staff in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	9	0	4	6	0	0
<b>Criteria</b>	0	30	0	7	6	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A complaints policy and procedures are in place. A flow chart visually describes the complaints process. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms.</p> <p>Information about the complaints procedure is provided to residents and their families in the information pack at entry. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are held in a visible location at reception.</p> <p>Interviews with residents and a relative confirm their understanding of the complaints procedure and state any concerns or issues raised have been addressed.</p> <p>The complaints log (register) includes the date of the complaint, name of complainant, summary of complaint, any follow-up actions taken and signature when the complaint is resolved. There have been three lodged complaints in 2014 with the appropriate acknowledgement, investigation and follow-up actions taken. All three complaints have been resolved. One complaint lodged with the Canterbury District Health Board (CDHB) in March 2015 relates to a resident's</p>



		cares. This complaint has been resolved with the family but remains open with the CDHB. Recommendations brought forth by the CDHB are in the process of being actioned.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>Five rest home level residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Interviews with residents and one relative with a family member in the dementia unit confirmed they are informed prior to entry of the scope of services of any items they have to pay for that are not covered by the agreement.</p> <p>Policies and procedures are in place for open disclosure. A sample of accident/incident reports reviewed evidenced family notification in only six of the ten accident/incidents. The facility manager and nurse manager can identify the processes that are in place to support family being kept informed.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents and their family/whānau are provided with this information at the point of entry. Families are encouraged to visit.</p> <p>The information pack is available in large print and is read to sight-impaired residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Annaliese Haven provides rest home and dementia level care for up to 63 residents in a 20 bed rest home wing and in two dementia units – 21 beds and 22 beds. On the day of audit, there were 50 residents - 19 rest home residents, and 31 dementia residents. The philosophy of care includes a mission statement and vision. The mission statement is included in the information booklet, which is given to each resident and family on admission.</p> <p>The business is privately owned and is one of four facilities owned and operated by Elsdon Enterprises. The facility was purchased in July 2013. The facility has undergone a recent change in management with the current manager employed on 2 April 2015. She is a registered nurse with a current practising certificate and has ten years of management experience in aged care roles. The manager reports directly to the general manager whom she meets with every week, face-to-face. A management plan is in place as per the request of the CDHB.</p> <p>The manager is supported by a clinical manager/registered nurse. The newly employed clinical manager began work on 4 May 2015. She and the manager</p>

		<p>both worked together at their previous employment.</p> <p>An organisational chart visually describes reporting relationships for the organisation. The service has a business/quality plan for 2015. This plan lists measurable goals. Dates for completion are documented with evidence of on-going monitoring.</p> <p>The manager has attended a minimum of eight hours of professional development annually relating to the management of an aged care service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management system is understood and implemented by the manager and clinical manager. They have been in their roles for six weeks and three weeks respectively. Gaps in the quality system are the result of a registered nursing vacancy and the period of time between the departure of the previous manager and employment of the new manager (approximately three months).</p> <p>Policies and procedures are in place. The manager reports new and/or revised policies have been developed with input from staff. The manager is required to sign off on all new policies. They are available for staff to read and to sign after reading. Policies are scheduled to be reviewed two-yearly unless changes occur more frequently.</p> <p>Key components of service delivery are linked to the quality and risk management programmes. The service has a business/quality plan in place for 2015.</p> <p>The internal audit programme involves monitoring areas of quality and risk. The manager is responsible for ensuring all internal audits are completed. Tasks are delegated to the staff where appropriate. On review of the completed audits for 2015 year-to-date, it is noted that the actual audits are not being completed as per the audit schedule.</p> <p>Data collected up to January 2015 has been analysed, evaluated and communicated to staff. Verbal discussion has been held at the monthly staff meetings and monthly quality management meetings. Meeting minutes are shared with staff. Corrective actions have not been documented in all instances. Where corrective actions have been developed there is little evidence to confirm that these have been completed, evaluated and signed off. This previous certification audit finding remains.</p> <p>Risks have been identified in the risk management plan and hazard register. The risk management plan includes a description of each identified risk, the risk rating, the controls and actions that have been put into place to prevent the risk from</p>

		<p>reoccurring and/ or how to deal with the risk in the event of its re-occurrence. Hazards have been identified on the hazard register. The register is updated as new hazards are identified. Falls prevention strategies are in place. Examples include the use of sensor mats and closely monitoring residents who are at risk of falling.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b> All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Moderate	<p>A sample of ten accident/incident forms were reviewed. Adverse events including (but not limited to): falls, skin tears, infections, medicine errors are documented on an accident/incident form by the person witnessing the event but are not always being investigated by a registered nurse. The GP is notified if required. Accident and incident data has not been collated and analysed since January 2015 (link to finding 1.2.3.6).</p> <p>Two of ten adverse events that were identified during the audit did not have an accident/incident form completed.</p> <p>Statutory and regulatory reporting obligations are understood by the manager and clinical manager.</p>
<p><b>Standard 1.2.7: Human Resource Management</b> Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are 54 staff employed by Annaliese Haven, which includes a manager (RN), a clinical manager (RN), a registered nurse, caregivers, kitchen staff, cleaning and laundry staff and activities staff.</p> <p>Annual practising certificates, including scope of practice, are validated with copies of certificates held in each applicable health professional's personnel file.</p> <p>Eight staff files were randomly selected for review (five caregivers, one diversional therapist, one registered nurse and the manager). Staff files included evidence of a signed employment agreement and position description, and appropriate qualifications. Police checks are conducted for all new staff. Staff undergo annual performance appraisals.</p> <p>Annaliese Haven has an orientation programme that is specific to worker type. Newly appointed caregivers are assigned to a suitably skilled caregiver to be their 'buddy'. New staff must demonstrate competency before working independently. Evidence of a completed orientation programme including evidence of competency was sighted in only two of eight staff files.</p> <p>A system is in place to identify, plan, facilitate and record on-going education for staff. The education programme covers more than eight hours annually of professional development relating to an aged residential care environment and</p>

		<p>meets contractual requirements. Training relating to restraint and cultural safety was provided in 2014 and is scheduled to take place again in 2015. This is an improvement from the previous audit.</p> <p>Caregivers in the dementia units are provided with the unit standards training. Of the 11 caregivers who work in the dementia units, nine have completed their dementia unit national qualification. Two caregivers who have been employed for over one year have yet to complete this qualification. The clinical manager is the infection control coordinator. She has not attended education and training specific to this role but is scheduled to attend training later in the year. Also, the cook has not completed a food safety certificate but is scheduled to attend later in the year.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A staffing levels and skills mix policy is in place that includes a documented rationale for staffing the service. Staffing rosters were sighted. Part time staff fill casual shifts. The manager (RN) and clinical manager are both employed full time and work Monday to Friday. The RN works Tuesday to Saturday. She was on leave during the audit. The registered nurses provide after hours on-call 24/7 when not on site. Care staff interviewed advised that they are well supported by manager and nurses. The roster includes a mixture of short and long shifts in each of the three units – rest home and two dementia units. There is a minimum of three care givers on duty overnight – with one in each unit. The manager reports that prior to her employment some staff were working back-to-back shifts. This practice was discontinued four weeks ago.</p> <p>Activities are provided by two staff, one being a diversional therapist. The activities staff work Monday through Saturday. A maintenance person/gardener is employed full time. There are designated cleaning and laundry staff.</p> <p>The manager reports staffing levels are able to be altered according to resident numbers and acuity.</p> <p>Residents and one relative interviewed confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Five residents' files were randomly selected for review. The resident files are appropriate to the service type. Entries are legible, dated and signed by the relevant caregiver or registered nurse and include their designation. This is an improvement from the previous audit.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>RNs and caregivers responsible for administering medication complete annual medication competencies and attend annual medication education. The clinical manager is also required to complete a medication competency.</p> <p>The service uses individualised medication blister packs for regular and as required (PRN) medications. Advised that medications are checked on delivery against the medication chart. Medication trolleys, fridge and cupboard stock contents were all within expiry dates and all eye drops were dated on opening. Medications are disposed of when they have expired. Medication administration practice was observed to be compliant. As required medications have the date and time of administration on the signing sheet. The service has addressed these aspects of the previous finding. There were no residents who self-administer their medications or any standing orders.</p> <p>Ten medication charts were reviewed (six dementia, four rest home). Two of the six charts (in dementia unit) had PRN medication charted with no maximum dosage for 24 hours. Two of the charts (rest home) sampled had no indications for use documented for PRN medication.</p> <p>Ten medication charts reviewed identified three monthly medication reviews signed by the GP.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>PA Moderate</p>	<p>The service employs a qualified cook Monday to Friday and a weekend cook. They are supported by a kitchen hand each day. A four weekly seasonal menu had been designed but not however, there was no documented evidence that the menu was been reviewed and approved by a dietitian.</p> <p>The cook receives a resident dietary profile for all new admissions and is notified of dietary changes however, nutritional profiles with likes and dislikes were not available for 34 of the 50 residents. Resident likes, dislikes and dietary preferences were known as it was displayed on a board.</p> <p>There were only one meal option identified on the menu for each meal with no alternative choice available. Food is delivered in a bain Marie to each area. Meal serving was observed on the day of the audit and observed to be warm and well-presented. Food temperatures are monitored twice daily and recorded. This is an improvement from the previous audit. Staff were observed sitting with the residents when assisting them with meals. There are snacks available over 24 hours for all dementia and rest home residents. Rest home residents interviewed expressed their satisfaction with the meal service.</p>

		<p>The service has a well equipped with kitchen. The freezer temperature and walk-in chiller is checked daily. All foods were dated and labelled. A cleaning schedule is maintained. Staff were observed wearing appropriate protective clothing. Chemicals were stored safely in the kitchen. Positive feedback on the food service has been received from resident and staff meetings, surveys and audits.</p> <p>Staff have been trained in safe food handling and chemical safety; however, the cook has not yet completed safe food handling training (link 1.2.7.5).</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Assessment templates were comprehensively completed in the sample of resident files reviewed. One file was sampled for a resident that transitioned from respite care to permanent care. An initial assessment was completed for this resident. Assessments are across all domains of care and are signed and dated by the RN. Risk assessments have been completed on admission and reviewed six monthly as part of the care plan review. This previous audit finding has now been addressed. Additional assessments for management of behaviour, pain and mobility were available and completed; however, wound assessments and wound documentation were not completed for three wounds (link to 1.3.6.1). All residents' files reviewed included formal assessments and risk assessments, which were reflected into care plans. A falls assessment was completed after a fall. Three resident files reviewed from the dementia unit included an individual assessment that included identifying diversional, motivation and recreational requirements. Challenging behaviours assessments were completed in all three files sampled from the dementia unit. The assessment identified triggers for the behaviours. This previous finding has now been addressed.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>Initial care plans and long term care plans were completed in all of the residents' files sampled, within the stated timeframes. There was evidence of changes to the care plan when health status changed. Four of five care plans reviewed are resident-centred and documented care and support needs. There was evidence of changes to the care plan when health status changed. One file (in the dementia unit) viewed had insufficient management strategies to manage challenging behaviour; however a behaviour chart was commenced and updated. This previous audit finding remains.</p> <p>Residents and one family member interviewed confirm care delivery and support by staff is consistent with their expectations. Family communication was documented in progress notes.</p> <p>Short term care plans were not in use nor completed for short term acute issues in</p>

		<p>three of the files (two from the dementia unit and one from the rest home). The clinical manager interviewed confirmed short term care plans have only recently been completed for residents with short term health issues.</p> <p>Two of three resident files reviewed from the dementia unit identified current abilities, level of independence and specific behavioural management strategies.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Four of the five residents' files reviewed evidence and record interventions that are consistent with the residents' identified needs and desired goals set (link to 1.3.5.2). Observations indicate residents are receiving appropriate care. Monitoring forms are completed as directed by the care plan e.g. food and fluid charts, weights, blood pressure and pulse and glucose monitoring. Three (two in the dementia unit and one in the rest home) weights were not recorded on the monitoring forms for four months; however the weights were documented in the progress notes.</p> <p>The residents in the rest home interviewed report they are involved in their own care and feel they are treated as an individual. The four dementia residents are unable to express all their needs but staff ensure they are able to clearly anticipate and provide the necessary cares required for each resident in the dementia unit. The one relative interviewed expressed how the service meets the needs of the resident. Interventions are monitored and reviewed by the team leaders and signed off by an RN. There is evidence of input by specialised health services however; two residents with complex needs (in the dementia unit) did not have documented evidence of other specialised services (link 1.3.4.2).</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. Continence assessments are performed and were sighted in all of the residents' files.</p> <p>There were three recorded wounds in the dementia unit (three skin tears). Wound management was documented in the progress notes; however, no wound assessment or planning documents were used for any of the three wounds. This previous audit finding remains. The clinical manager interviewed confirms that a wound care specialist is available for advice. There were no recorded wounds in the register in the rest home. Short-term care plans were not utilised consistently for residents with short-term health issues and wounds (link to 1.3.5.2). Any changes to the long term care plans were dated and signed.</p> <p>The general practitioner interviewed discussed the improvement in care, management and consistency of this with the new manager and the recent</p>

		appointment of the clinical manager.
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>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.</p>	FA	<p>Two activity officers are responsible for implementation of activity programmes for the rest home and dementia unit. The activity programmes are delivered Monday to Saturday. Both staff have current first aid certificates.</p> <p>Activities were observed to be delivered simultaneously in the rest home and dementia unit. The programmes include housie, speakers, exercise, memory games, biweekly, van outings and weekly church services. Resources were available for staff use at any time. Daily contact is made and one-on-one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme.</p> <p>An activity plan is developed for each resident and the residents are encouraged to join in activities that are appropriate and meaningful. Resident meetings were held monthly and open to families to attend.</p> <p>The activity plans were reviewed at the same time as the clinical care plans in resident files sampled.</p> <p>Activity plans are linked to the residents' care plans and make provision for de-escalating techniques and activities for those residents with challenging or wandering behaviour.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>The documented evaluations indicate the residents' progress in meeting goals. There is a multidisciplinary review and the plan is updated to reflect progress towards meeting goals. The evaluation and care plan review policy require that care plans are reviewed at least six monthly. The written evaluation template describes progress against every goal and need identified in the care plan.</p> <p>All of the initial care plans sighted had been evaluated by the RN within three weeks of admission. Four of five care plans were evaluated six monthly or more frequently when clinically indicated.</p> <p>Activities care plans are evaluated by the activities officers; however, five files sampled have no RN input or signature. Care staff interviewed confirm that they are made aware of changes in residents' health or care at the beginning of each shift.</p> <p>Family are invited to attend the multidisciplinary review (MDR) meetings. The GP confirmed that he is invited to the multi-disciplinary meetings but rarely has time to</p>



		attend.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The building holds a current warrant of fitness, which expires on 31 May 2016. Electrical equipment is checked annually. Medical equipment has been calibrated by an authorised technician. This is an improvement from the previous audit.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	Surveillance frequency and type is set out in the policy and is determined by the service's infection control policies and procedures that are reflective of this aged care residential care service. The infection surveillance data is required for the monthly clinical indicators. Infection control data is collected on relevant types of infection such as urinary tract infections, lower respiratory infections, flu, chest infections, skin and wound infections, oral infections and other infections. The monthly data collected in the form of a report by the infection control coordinator who at this facility is the clinical manager. The infection control report is provided to the quality meeting with any recommendations. Results are fed back to the staff at the monthly staff meetings. Surveillance results are being analysed.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	The use of enablers is voluntary and the least restrictive option to meet the needs of the resident with the intention of promoting or maintaining resident's independence and safety. There were no resident's using restraints or enablers at the time of the audit. Policies and procedures are comprehensive to guide staff in the event that restraint or enablers should be needed and these align with the standard. A checklist for safe and appropriate use of restraints is available. Training on managing challenging behaviours has been conducted.

## 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)
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Policies and procedures are in place for open disclosure. One relative with a family member in the dementia unit reports that they are kept informed, however, six of ten accident/incident forms (during the months of April and May 2015) were missing evidence of disclosure to families. This was predominately during instances where an accident had occurred, but an injury had not been sustained.</p>	<p>Following a review of incidents and accident forms for April and May 2015, and a review of corresponding resident files, it was noted that families were not informed of resident incidents in six of ten incidents reviewed.</p>	<p>Ensure family are kept informed following all accidents/incidents unless family/residents request otherwise.</p> <p>90 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results</p>	PA Low	<p>Data is collected from accidents, incidents, infections, internal audits, and resident satisfaction surveys. Infection data was sighted. However</p>	<p>The internal audits have not been completed as per the internal audit schedule. Quality data has not been collated, trended or analysed since</p>	<p>Ensure internal audits are completed as per the audit schedule and quality data collected is collated, trended and analysed in a timely</p>

communicated to service providers and, where appropriate, consumers.		other quality data has not been collated, trended and analysed since January 2015. There was a gap in leadership at the facility during this time.	January 2015.	manner.  90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Where corrective actions have been developed for identified shortfalls in service compliance, there is little evidence to show that these have been completed. Corrective actions have not been developed for every opportunity identified for improvement via internal audits, surveys, resident and staff feedback. Staff report corrective actions and improvements are identified and discussed in staff meetings.	Corrective actions are not consistently developed following quality activities. Those corrective actions that have been documented are not consistently completed and evaluated. Examples include corrective actions around internal audit results, satisfaction survey results and adverse event trends.	Ensure corrective action plans are documented and evaluated for areas that require improvements.  90 days
<p>Criterion 1.2.4.3</p> <p>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.</p>	PA Moderate	<p>Ten accident/incident forms were selected from the months of April and May 2015. Each adverse event was documented and was signed by the person who witnessed the event. Five of the ten accident/incident forms did not evidence full investigation by a registered nurse.</p> <p>Two incidents that were made known to the auditors during the audit (one pressure injury, one fall) did not have an associated accident/incident</p>	Five out of ten accident/incident forms reviewed for April and May 2015 were not investigated by a registered nurse. Two adverse events that were made known to the auditors during the audit did not have an associated accident/incident form completed.	Ensure that a registered nurse conducts investigations following an accident/incident. Also ensure that each accident/incident is reported via the reporting processes.  30 days

		form completed.		
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>Eight staff files were randomly selected for review. Evidence of a completed orientation programme was evidenced in only two of the eight staff files audits. The manager reports that all staff are provided with a comprehensive orientation programme but the staff often forget to return orientation paperwork to evidence completion of the programme. Interviews with care staff report that the orientation programme is adequate to meet the needs of the residents. They report that the time allocated to orientating new staff has improved since the recent employment of the new manager.</p>	<p>Documented evidence of staff completing their orientation programme was evidenced in only two of eight staff files audited.</p>	<p>Ensure staff files contain evidence of staff completing their orientation programme.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Education for staff is provided as in-services, self-directed reading and learning or attendance at off-site sessions. Mandatory training has been well attended by staff. Nine in-services have been provided for staff throughout May 2015. Eleven caregiver staff are employed to work in the dementia unit with two staff remaining to complete their dementia qualification. Training requirements are not</p>	<p>The cook has not completed a food safety certificate and the infection control coordinator (clinical manager) has not completed external infection control training. Both the infection control coordinator and the cook are scheduled to attend training later in the year. Two caregiver staff who are working in the dementia units have been employed for over one year and have not completed a national certificate in dementia.</p>	<p>Ensure the two caregiver staff who work in the dementia unit and have been employed for over one year complete their dementia national qualification. Ensure the infection control coordinator attends external infection control training and the cook completes food safety training.</p> <p>180 days</p>

		being met for the infection control coordinator and cook although scheduled for later this year.		
<p>Criterion 1.3.12.1</p> <p>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.</p>	PA Moderate	<p>The service has a medication policy. Medications are checked on delivery against the medication chart and administered as prescribed. Medication administration was observed to be compliant. Ten medication charts were reviewed (four from the rest home, six from the dementia unit) with six charts completed appropriately. There were two signatures on the medication sheet and other medication records whenever specialised medications were administered. Expiry medication is send back to the pharmacy to be disposed of. The pharmacist conducts weekly checks with the weekly delivery of specialised medication.</p>	<p>Two of the six charts (in dementia unit) had PRN medication charted with no maximum dosage for 24 hours. Two of the charts (rest home) sampled had no indications for use documented for as required medication.</p>	<p>Ensure as required (PRN) medication documents a maximum dose and ensure PRN medication orders include indications for use.</p> <p>60 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	<p>Staff responsible for administering medication have annual medication competencies completed. The clinical manager, who is responsible for signing off on staff medication competencies in the absence of the staff RN, has not completed hers.</p>	<p>The clinical manager has not completed a medication competency.</p>	<p>Ensure the clinical manager completes all required medication competencies.</p> <p>90 days</p>

<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Moderate</p>	<p>There is a four week seasonal menu. There was no documented evidence that the menu was been reviewed and approved by a dietitian. The cook and kitchen hand interviewed were familiar with the residents nutritional needs and that a dietary profile is received for each resident. There were sixteen (of fifty) nutritional profiles available. Residents' likes and dislikes were displayed on a board in the kitchen. There was evidence of nutritional snacks made available over 24 hours for the residents in the rest home and dementia unit. The cook explained the process of keeping the food warm and explained the different consistency of the meals provided.</p>	<p>There was no evidence of documented dietary profiles for 34 of the 50 residents. Dietary profiles reviewed have not been signed, dated or reviewed. There was no evidence of dietitian review of the menu. There was no evidence of an alternative meal choice for residents.</p>	<p>Ensure all residents have a nutritional profile available in the kitchen. Ensure nutritional profiles are signed, updated and reviewed with the six monthly care plan review. Ensure evidence of dietitian input into the menu is documented. Ensure alternative meal options are available on the menu.</p> <p>60 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Staff could describe a verbal handover at the beginning of each duty that maintains a continuity of service delivery. Care staff write daily in the progress notes. Three files reviewed identified integration of allied health and a team approach is evident. The GP interviewed reported that the registered nurses consult with the GP with any concerns regarding residents' health</p>	<p>Nursing management/assessment and input have not been documented in the progress notes for the last month in two of three residents' files in the dementia unit. Two files (in the dementia unit) have issues/changes of health status identified that require RN follow up but no RN documentation in the progress notes around the issue. Two residents (in the dementia unit) with complex needs did not have evidence of allied health input a) one with severe mobility issues and b) one with continuous</p>	<p>Ensure that all residents have regular and as required input from a registered nurse and that this is documented in progress notes.</p> <p>Ensure residents with complex needs are referred for specialist input in a timely manner.</p> <p>30 days</p>

		status and he believes the service provided meets residents' needs. The GP routinely visits weekly and is available at all times for urgent matters. One relative interviewed stated she is well informed by the staff. Further improvements are identified relating to RN input and referrals for specialist input.	challenging behaviour.	
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	Care plans are individual and goal orientated. Four of five files reviewed documented comprehensive interventions to guide staff in the care of the resident. Interventions are changed according to changes in need and when evaluations occur. Short term care plans templates are available for use for acute health issues, however, were not completed for three resident issues.	<p>One resident who displays continuous challenging behaviour had insufficient interventions in place to guide staff.</p> <p>Short term care plans were not completed for three residents: a) one resident in the rest home with a urinary tract infection; b) one resident in the dementia unit with a skin tear and c) one resident in the dementia unit with a urinary tract infection.</p>	<p>Ensure that care plans have interventions that relates to all identified areas of need.</p> <p>Ensure short term care plans are completed for all acute health issues.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	Interventions were resident focussed. Monitoring charts were in use and completed as directed in the care plans. Food and fluid charts, glucose monitoring, blood pressure, pulse, and weights were completed as directed by the care plans. Care staff interviewed confirmed that there is sufficient equipment to perform their duties. The	<p>Three (two in the dementia unit and one in the rest home) weights were not recorded on the monitoring forms for four months; however the weights are documented in the progress notes.</p> <p>Wound management is documented in the progress notes; however, no wound assessment or planning documents are used for any of the three wounds in the dementia unit. Nor is it linked to a short term care plan.</p>	<p>Ensure weights are recorded on the monitoring form.</p> <p>Ensure all wounds have a comprehensive assessment, monitoring and documentation completed and linked to the short term care plan.</p> <p>60 days</p>

		<p>residents expressed satisfaction with the care and that it is consistent with their needs. Wound management was recorded in the progress notes. There was evidence that specialised services were consulted for advice in two of the files reviewed (physiotherapy referral for a resident in the rest home and dietitian for a resident with swallowing difficulties) (link to 1.3.3.4).</p>		
<p>Criterion 1.3.8.2</p> <p>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.</p>	PA Low	<p>Evaluations are documented six monthly and indicates the residents' progress in meeting their goals. Care plan evaluations were missing in one of the residents' files reviewed. Activity care plans are evaluated the same time as the clinical care plans. Changes in health care status or care are transferred to the interventions of the care plan.</p>	<p>One care plan evaluation (rest home) had not been completed. The resident care plan evaluation is overdue by three month and has not been conducted since admission.</p>	<p>Ensure all care plans are evaluated within the required timeframe.</p> <p>90 days</p>



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

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

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

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

No data to display
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End of the report.