# CHT Healthcare Trust - Bernadette Life care

## Introduction

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

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

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

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

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** Bernadette Life Care

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

**Dates of audit:** Start date: 2 September 2015 End date: 3 September 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:** 77

# 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

CHT Bernadette is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital level care for up to 113 residents. On the day of the audit, there were 26 rest home (of which four were on respite care) and 47 hospital level residents (of which one was young physically disabled and one was on respite care). The unit manager is a registered nurse and maintains an annual practicing certificate. She has been in the role for three weeks and has previously managed another CHT facility.

This unannounced surveillance audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents’ and staff files, observations and interviews with residents, relatives, staff and management.

The service has rectified two of seven findings from the previous audit around faxed medication charts and nutritional assessments. Shortfalls continue around full implementation of the quality system, HR and recruitment processes, resident assessment and care planning and restraint monitoring.

This audit also identified shortfalls around complaints management, medication management, wound care, activities plans, care plan evaluation, infection control and training.

## 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. |

Staff demonstrate an understanding of residents' rights and obligations. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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

The unit manager is a registered nurse and she is supported by an area manager, an acting clinical coordinator, registered nurses and care staff. The organisation has a quality and risk management programme, which includes service philosophy, goals and a quality planner. Residents meetings have been held and the annual survey as well as monthly internal surveys has been sent out to residents and families. Health and safety policies, systems and processes are being implemented to manage risk. Incidents and accidents are reported and followed through. The organisation has a comprehensive education and training programme. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are administered in line with legislation and current regulations. 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

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

The service is preparing for a refurbishment of the rest home wings. There is a documented building warrant of fitness.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were ten residents requiring restraints and seven residents using enablers. The staff are trained in restraint minimisation.

## Infection prevention and control

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

Appropriate infection control practices were observed during the audit. The organisation has an infection control programme, which meets the needs of the organisation and provides information and resources to inform the service providers. This includes the type of surveillance to be undertaken which is appropriate to the size and complexity of the organisation.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 7 | 0 | 4 | 7 | 0 | 0 |
| **Criteria** | 0 | 28 | 0 | 5 | 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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | PA Low | A complaints policy and procedure is in place and residents and their family/whānau have been provided with information on admission around complaints. Complaint forms are available at the entrance to the service. Staff are aware of the complaints process and to whom they should direct complaints. Documented complaints include a Health and Disability complaint, which is currently in progress. This complaint has a documented clinical risk action plans in place. A complaints folder has been maintained. Complaints documented for 2015 have not been managed as per policy.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures, and policy around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten of 33 incidents/accidents forms for August were viewed. The form includes a section to record family notification. All ten forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirm they are notified of any changes in their family member’s health status. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau has difficulty with written or spoken English, the interpreter services are made available. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | CHT Bernadette is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital level care for up to 113 residents. On the day of the audit there were 26 rest home (of which four were on respite care) and 47 hospital level residents (of which one was young physically disabled and one was on respite care). The unit manager is a registered nurse and maintains an annual practicing certificate. She has been in the role for two weeks and has previously managed another CHT facility. The acting clinical coordinator has been in the role since April 2015 she was previously a registered nurse at Bernadette. The unit manager reports to the CHT area manager weekly on a variety of operational issues. CHT has an overall business/strategic plan and Bernadette has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care which includes a mission statement. The unit manager has completed in excess of eight hours of professional development in the past 12 months.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is an organisational business/strategic plan that includes quality goals and risk management plans for CHT Bernadette. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Reporting of quality outcomes to meetings is not well documented, and full implementations of the internal audit schedule are identified areas for improvement. The service has an ongoing action plan to fully implement all of the CHT processes, including the quality and risk programme. Undertaking audits remains a finding from the previous audit. Staff interviewed confirmed that they have knowledge of the organisations quality system. There is a hazard register, which includes type, potential harm, action to minimise, control measures, consequences and probability. Falls prevention strategies such as low beds are implemented as per resident plans.Four caregivers and two registered nurses described the increased support and information that is beginning to be disseminated to the team, with caregivers stating that the new manager is proactive with feedback and action planning for improvement. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Incident and accident data has been collected and analysed. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of 10 resident related incident reports for August 2015 was reviewed. All reports and corresponding resident files reviewed, evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service benchmarks incident data with external quality indicators. There was no documented discussion of incidents/accidents at monthly quality meetings or staff meetings including actions to minimise recurrence (Link 1.2.3.6).  |
| 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 Moderate | Five staff files were reviewed. A copy of practising certificates is kept. Four of five files reviewed were staff who had been employed by the previous owner. The fifth file was employed since change of owners. Shortfalls were identified around reference checks, job descriptions and completed orientations. These were identified shortfalls in the previous audit and remain open.The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed described being orientated to their roles. The in-service education programme for 2015 is being implemented. Healthcare assistants have the opportunity to complete an aged care education programme. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. The new service provider (CHT) has not undertaken staff appraisals yet.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | CHT policy includes staff rationale and skill requirements mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse (RN) is on at any one time. The clinical manager works full time and she is in addition to the RN on duty. The unit manager is also a RN. Extra staff can be called on for increased residents. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| 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 packs, which are checked in on delivery. Two registered nurses were observed administering medications correctly. Medications and associated documentation were stored safely and securely and all medication checks were completed and met requirements. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies, or nil known, were on all ten medication charts reviewed. An annual medication administration competency was completed for all staff administrating medications and medication training had been conducted. There is a self-medicating resident’s policy and procedures in place. Residents who are self-administering medications store their medications in a locked cupboard and are deemed competent. ‘As required’ medication was reviewed by a registered nurse each time prior to administration. Medication charts reviewed identified that the GP had reviewed the resident at least three monthly and the medication chart was signed.The medication charts were easy to read and only one copy was on the ten resident medication charts reviewed. This is an improvement on the previous audit. Shortfalls were identified around medication documentation/management.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at the service are prepared and cooked on site by an external contractor. There is a four weekly winter and summer menu, which has been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen and served to the residents from the kitchen or in hotboxes. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. The service records all fridge and freezer temperatures. Staff were observed serving and 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 via the registered nurses. Alternative meals are provided as required. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. |
| 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. There is a documented process and policy around the resident assessment process. New residents (two respite and one new long-term resident) have a range of assessments completed on admission. The six monthly reviews of assessments are not completed for the four residents who have been admitted over six months. Dietary profiles are in place for all residents. This is an improvement on the previous audit. Pain assessments continue to be an area for improvement.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | There are documented policies and procedures around care planning. Care plan interventions continue to lack detail and do not always reflect the assessments and the identified requirements of the residents. This remains a finding from the previous audit. This audit also identified that care interventions such as observations and weights are not always documented as occurring according to the care plan. Interviews with staff (two registered nurses and four caregivers) seven residents and four relatives confirmed involvement of residents/families in the initial assessment and care planning process. Dressing supplies are available and treatment rooms are stocked for use. Continence products are available and resident files included continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described. The service has 13 identified wounds (some residents with more than one) and eight pressure injuries (Hospital; three grade two, one grade one, and four with no documented grades), all have an initial wound assessment and plan. There are two wound care templates in use the ‘old’ provider templates and CHT templates. Shortfalls were identified in documentation of wound care. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | The service employs a Diversional Therapist, and an activities staff member. The activities staff provide an activities programme over five days each week at present although the service is set up for a seven day a week operation. The programme is planned monthly and residents received a personal copy of planned monthly activities. Residents are encouraged to join in activities. The service has a van for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. Since the previous audit the service has made improvements such as movie trips, being part of inter-rest home games, monthly shopping trips, library visits and new card games and special interest groups. This has all been as a result of resident feedback. This audit identified shortfalls around individualised resident activity plans and six monthly reviews/evaluations. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | There was evidence that aspects of care plans had been updated as changes were noted in care requirements. Short-term care plans are utilised for residents and were dated and signed. The evaluation of care plans is an area for improvement.  |
| 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 rest home has three wings, one wing has been recognised by CHT as not being to the standard they expect (nine beds) and the other two wings (29 beds) will be refurbished CHT architects are commencing the planning process to upgrade these wings. There is a documented BWOF for the service expiring 22 April 2016.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | PA Moderate | Infection surveillance is an integral part of the infection control programme and is described in CHT’s infection control manual. Monthly infection data is not currently being collected at CHT Bernadette. Therefore, no infection data is monitored or evaluated. The unit manager has an action plan in place to correct this. Short-term care plans are used. This data is monitored and evaluated monthly and annually. There is no documented discussion of infections, outcomes or actions at staff meetings. There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by a restraint coordinator who is the acting clinical coordinator. There were 10 hospital residents requiring bedrails or sit-safes as restraint. Seven hospital residents were using bedrails as enablers. The use of enablers is voluntary, requested by the resident. A full restraint assessment is completed prior to implementing the enablers. There is evidence of the residents consenting to the enabler. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | PA Moderate | The restraint minimisation manual identified that restraint is only put in place where it was clinically indicated and justified and approval processes. Two files were reviewed for residents with restraint and both had a completed assessment form and consent in place and a care plan that reflects risk. A care plan reviewed of a resident with an enabler, had this clearly documented in the care plan and this is an improvement on the previous audit. Monitoring of restraint remains a finding from the previous audit. The service has a restraint and enablers register, which is updated each month. |

# Specific results for criterion where corrective actions are required

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

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

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

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.1The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | There are CHT systems and processes to manage complaints. The manager and area manager are proactive with following up both new complaints and ensuring that old complaints have been appropriately managed. This is an ongoing process. However, the eight complaints reviewed for 2015 were not managed as per policy. | Eight complaints were reviewed for 2015 and of the eight, all either had a late reply to the complaint or the follow up has been verbal with no documented close off. | Ensure that complaints are documented as followed up in a timely manner.90 days |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Data is collected by the Bernadette as directed by CHT in relation to a variety of quality activities and this is discussed at a management level. The organisation uses the data collected for benchmarking purposes against other CHT sites. There is no documented evidence of quality data being discussed at staff meetings. Resident meetings are held monthly. The organisation has an audit schedule. Staff interviewed confirmed that audits have taken place as per the audit schedule but there is no documented evidence of audits having occurred since March. There is documented evidence of minutes for all meetings that have been held since the new manager commenced. There is no documented evidence of meeting minutes from March to August. | i) There was no documented evidence of any internal audits having occurred since change of owner in March. ii) There was no evidence of quality data being discussed with the Bernadette staff at staff meetings. | i) Ensure internal audits are completed as per audit schedule and ensure actions are discussed at staff meetings to monitor service delivery and address areas that require improvement. ii) Ensure quality data is shared with all staff.60 days |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Moderate | CHT has a policy in place, which includes the developing of corrective action plans for areas identified as requiring improvement at internal audit. There were no corrective action plans in place at Bernadette at the time of the audit. | There was no documented evidence of any corrective action plans having been developed or implemented since March. | Ensure that corrective action plans are developed and implemented for all areas identified as requiring improvement.60 days |
| Criterion 1.2.7.3The appointment of appropriate service providers to safely meet the needs of consumers. | PA Moderate | There are human resource management policies in place, including that the recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. The previous finding around reference checks and job descriptions remains open. | (i) One of five files reviewed (a new employee) did not have evidence of reference checks occurring before employment was offered. (ii) Five of five files did not contain job descriptions. | (i) Ensure reference checks are carried out before employment is offered. (ii) Ensure all staff have a relevant signed job description in their file. 60 days |
| Criterion 1.2.7.4New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Moderate | The organisation has a comprehensive orientation programme. The unit manager confirmed that there is a plan in place to ensure all staff have documented evidence of having completed the orientation programme. The previous audit identified a shortfall around completed orientations on staff files. This audit identified a lack of orientation documentation in staff files reviewed and therefore this finding remains open. | Five of five files reviewed had no documented evidence of completion of the orientation programme. | Ensure all staff complete the orientation programme and this is documented in their files.60 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The organisation has an education plan in place for 2015 this is in the process of being implemented at Bernadette. A variety of education sessions have been completed in 2015 since change of owner. Opportunist education sessions have not been held. The unit manager confirmed that all staff who administer medication have a current medication competency. | Following an allegation of abuse, there were no extra education sessions arranged for the staff on abuse and neglect. | Ensure extra education sessions are arranged when required in response to incidents that occur within the facility.60 days |
| Criterion 1.3.12.1A 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 | There are comprehensive medication policies in place, which directs safe medication storage, administration and reconciliation. Any required changes to medication charts are faxed to the GP for updating, if the GP is not available onsite at the facility. Original medication charts are to be updated by the GP as soon as practicable to prevent ongoing use of faxed copies. Shortfalls were identified around medication documentation and management. | (i) The fridge in the upstairs hospital has no temperature monitoring in place; (ii) Two medication charts had no stop date documented for antibiotics; (iii) One medication signing chart has evidence of transcribing, and (iv) One medication chart signing sheet for regular medication has signing gaps . | (i) Ensure fridge temperature monitoring, (ii) Ensure GPs include stop dates, (iii) Cease the practice of transcribing, (iv) Ensure medications are signed for on administration. 60 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | The registered nurses are responsible for all aspects of resident assessment, care planning and evaluation of care. Registered nurses developed five of five long-term care plans and two respite plans. Four of five long-term care plans were completed within three weeks. Of the four resident’s residing over six months, all four did not document any assessment review or evaluation since 2014 (link 1.3.8.2). One of two respite residents did not have a care plan in place. | (i) Of the two respite resident files reviewed, one did not have a care plan and one had a care plan that was only partially completed. (ii) One rest home resident did not have a long-term care plan completed within three weeks. | Ensure residents have a completed care plan with in specified time frames.60 days |
| Criterion 1.3.4.2The 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 are policies around assessing residents’ requirements and goals to guide the level of service delivery. The new residents have a range of assessments in place. Four RNs are trained with InterRAI and three are in the process of training. The service is undertaking a process of reviewing all resident files and are moving the documentation over to the CHT process (from the previous provider’s documentation). There continues to be shortfalls around assessments. | (i) Pain assessments were not evidenced in any of the five long-term resident files reviewed. (ii) Ongoing six monthly re-assessments have not been completed this year for the four longer-term residents. (iii) The newly admitted rest home resident did not have an InterRAI assessment within three weeks of admission. | To ensure all residents identified with pain have a current pain assessment completed, new residents have an InterRAI assessment within three weeks and assessments are reviewed and updated six monthly or as needs change.60 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | The service has a combination of care plan templates, this includes the ‘old’ provider templates, CHT and V care computerised care plans, all templates are appropriate for the service. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. The service has commenced the process of implementing computerised care planning. | 1) Rest home; one resident had no care plan and one had a partially completed Vcare plan. In the hospital, three of four files did not document care interventions in the care plans. Examples include; palliative care needs, mobilisation and use of hoists, use of a bed cradle, recognition and treatment of hypoglycaemia, management of high falls risk and pain management. 2) Care plan interventions such as weekly weights (two hospital residents) weekly observations (one hospital resident) are not documented as occurring. 3) The evaluation of wounds and care provided has been not been documented until late July/early August 2015 for all wounds plans reviewed. There are no documented wound evaluations after this date on the wound care plans. Staff advise that they now review wounds in the progress notes. A review of progress notes evinces that either there is no evaluation documented, or generic statements such as ‘improved’ are used. As a result, it is unclear as to the status of the wounds including the pressure injuries and the dressings that are in use. Examples include the tracer in hospital level who has three pressure injuries documented; staff inform that two have healed. In addition, the rest home tracer with a skin graft and donor area, it is unclear as to the dressing to be used and the progress of the wounds. | 1) To ensure that all long-term care plans reflect the current assessments and offer clear, precise instructions and contain detailed resident preferences to care staff and registered nurses regarding individualised care, 2) Care plan instructions are documented as occurring, 3) Wound care plans and evaluations give clear instruction and identify the wound healing progress.60 days |
| Criterion 1.3.7.1Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Five resident files reviewed all had an activity plan documented. | The individual activity plans for all residents reviewed are generic and do not reflect individual preferences. Three additional care plans were checked at random to review the content of the individual activity plans and these three were also generic. The four resident files reviewed for residents who had been at the service for over six months did not evidence a review or evaluation of activities. | Ensure that activity plans reflect personal preferences and needs and are evaluated six monthly.90 days |
| Criterion 1.3.8.2Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Short term care plans were evidenced in all resident files and, one rest home and two hospital files had some updating of care plans documented with change of resident need.  | Four of four care plans (one rest home and three hospital) for longer term residents did not have a documented evaluation within the last six months.  | Ensure that care plans are evaluated six monthly. 90 days |
| Criterion 3.5.7Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | PA Moderate | CHT has an infection control policy which when implemented will provide the unit manager with readily accessible data which can be shared with staff. An example of this was viewed during the audit. | There was no documented recording of infections at CHT Bernadette. This in turn meant that there was no evaluation of infections, which would assist in the possible reduction and prevention of infection. | Ensure that all infections are recorded and evaluated. Ensure that this information is shared with staff.60 days |
| Criterion 2.2.3.4Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:(a) Details of the reasons for initiating the restraint, including the desired outcome;(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;(c) Details of any advocacy/support offered, provided or facilitated;(d) The outcome of the restraint;(e) Any injury to any person as a result of the use of restraint;(f) Observations and monitoring of the consumer during the restraint;(g) Comments resulting from the evaluation of the restraint. | PA Moderate | Restraint is only put in place where it was clinically indicated and justified and approval processes. Staff interviewed were fully aware of residents using restraint and enablers. Monitoring charts reviewed were not being documented as per policy and this finding remains open. | (i) There was no monitoring for one resident using bedrails as restraint, and (ii) one resident did not have two hourly monitoring documented on the monitoring form as directed in the care plan. | Ensure monitoring of restraint is documented.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.

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End of the report.