# T M & D L Beer Holdings Limited - Kenwyn

## 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:** T M & D L Beer Holdings Limited

**Premises audited:** Kenwyn Rest Home

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

**Dates of audit:** Start date: 15 December 2015 End date: 15 December 2015

**Proposed changes to current services (if any):** The service has applied for three additional dementia care beds. This audit has assessed two refurbished rooms and three additional rooms in the dementia unit as suitable for use within the dementia unit.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 52

# 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

Kenwyn Rest Home cares for up to 59 residents requiring hospital, rest home and dementia level care. On the day of the audit, there were 52 residents.

This unannounced surveillance audit was conducted against a subset of the 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 dementia unit has undergone renovation work. Two existing rooms have been refurbished and three new rooms have been built on. This audit has also assessed the service as able to cater for three extra residents in single rooms within the secure dementia unit.

The executive nurse manager/registered nurse has been in the role for four years and works at this site and another site owned by the same owners in another town and has worked in the aged care sector for 18 years, holds post graduate qualifications in advanced nursing and is supported by a senior registered nurse.

Residents and family interviewed spoke positively about the service provided.

The specific area of the one previous shortfall has been addressed. However, further improvements are required around other areas of medication documentation. This audit identified improvements required around incident management, internal audits, corrective action plans, timeliness of documentation, care plan interventions and aspects of medication management.

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

Complaints processes are implemented and complaints and concerns are managed and documented. Residents and family are well informed, including changes in resident’s health. The executive nurse manager has an open door policy.

## 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. |

Kenwyn has an established quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to facility meetings. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely.

## 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. |

Registered nurses complete initial assessments and risk assessment tools on 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. Staff administer medication from doctor’s prescription charts that had been reviewed three monthly. The provision of food, fluid, and nutritional needs of residents are 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 building has a current warrant of fitness. The three new rooms in the dementia unit are appropriate for dementia level residents and there are adequate toilets and showers and communal areas to accommodate three extra residents.

## Restraint minimisation and safe practice

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

A restraint policy includes comprehensive restraint procedures and aligns with the standards. There were five residents requiring restraints and three residents using enablers on the day of the audit. Enabler use is voluntary.

## Infection prevention and control

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

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes hand hygiene and surveillance of infection control events and infections.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 9 | 0 | 3 | 3 | 1 | 0 |
| **Criteria** | 0 | 32 | 0 | 5 | 3 | 1 | 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. | FA | A complaints policy and procedures have been implemented and residents and their family are provided with information on admission. Complaint forms are available throughout the service. Staff interviewed were aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. There have been 11 complaints in 2015. The complaints reviewed had documented evidence that they been managed and resolved appropriately. Residents and family members advised that they are aware of the complaints procedure and how to access forms. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents (four rest home and two hospital) and family members interviewed (one dementia, one hospital and one rest home) stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and given time and explanation about services and procedures. Resident/relative meetings take place and the executive nurse manager has an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or families have difficulty with written or spoken English, interpreter services are available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | PA Low | Kenwyn is privately owned and operated. The service provides care for up to 59 residents at rest home, hospital and dementia levels of care. The dementia unit can care for up to 19 residents. The rest home and hospital has 40 beds (eight dual-purpose, 12 hospital and the remaining rest home). On the day of the audit, there were 16 residents in the dementia unit, 12 hospital residents and 24 rest home residents. All residents were on the aged residential care contract. This audit included assessing two refurbished rooms and three new bedrooms in the dementia unit. An experienced executive nurse manager, who holds a post graduate qualification in advanced nursing and is also the clinical manager at the owners other facility in another town, manages the service. She receives support from the general manager, the registered nurses and long standing care staff. The current business plan was implemented in February 2013; however, there is no documented evidence of this having been reviewed. The executive nurse manager has completed at least eight hours of training related to management of a rest home and hospital. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The quality manual and the quality, risk and management planning procedure describes Kenwyn’s quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the monthly staff meetings. A monthly trend analysis of data has been completed for all areas of the service. Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff (including six caregivers, one registered nurse and the facility executive nurse manager) confirmed their involvement in the quality programme. Resident/relative meetings have been held bi-monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is an internal audit schedule in place for 2015. There was no documented evidence of all the audits on the schedule being completed, although the executive nurse manager advised that they had been completed or were in the process of being completed. Areas of non-compliance identified at audits were not consistently actioned for improvement or where identified, were not signed off to evidence completion. The service has an established health and safety management system. There are established risk management, and health and safety policies and procedures in place including accident and hazard management. The service has policies/procedures to support service delivery. Policies and procedures align with the client care plans. Processes around interRAI are included in service delivery policies. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Residents are surveyed to gather feedback on the service provided, however, there is no documented evidence that the outcomes are communicated to residents and families. The residents’ survey outcomes are fed back to staff at staff meetings.  Falls management strategies include sensor mats, intentional rounding and the development of specific falls management plans to meet the needs of each resident who is at risk of falling. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA High | There is an accident/incident reporting and open disclosure policy/procedure. There is indicator month-by-month data collection. Monthly aggregation of data is undertaken (monthly summaries sighted) and outcomes are discussed at staff meetings.  Thirty-nine incident forms sampled evidence investigations following incidents for two incidents. Not all incident forms sampled where there has been a head injury sustained, have been followed up with neuro-observations. Not all forms have clinical follow-up documented and none have been reviewed by the executive nurse manager. Care plans have not been updated in response to incidents. Not all identified incidents are documented on an incident form.  The caregivers and the registered nurse interviewed could describe the process for management and reporting of incidents and accidents.  Discussions with the executive nurse manager confirms an awareness of the requirement to notify relevant authorities (DHB) in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | The recruitment and staff selection process requires that relevant checks be completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (one registered nurse, two caregivers, one activity coordinator and the kitchen manager) and included all appropriate human resource documentation. The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals were conducted in all staff files sampled. An in-service education programme has been completed for 2015, which covered required areas including manual handling. The executive nurse manager and registered nurses attend external training including seminars and education sessions with the local DHB. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Kenwyn has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents including the additional beds in the dementia unit. There is a registered nurse on duty at all times and a second registered nurse in the mornings during the week. The executive nurse manager and/or general manager are on site five days per week. The ENM reports that she works at least three days per week at Kenwyn and is on call at other times. Caregivers, residents and family interviewed advised that sufficient staff are rostered on for each shift. |
| 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 | An RN checks medications against the doctor’s medication profile on arrival from the pharmacy. Any mistakes by the pharmacy are regarded as an incident.  A registered nurse in the rest home/hospital and a caregiver in the dementia unit were observed administering medications. All staff who administer medications have been assessed as competent.  Resident medication charts are identified with demographic details and photographs. The medication fridges have weekly temperature checks. All 10 medication charts had allergies (or nil known) documented.  All medications except eye drops are stored appropriately.  No residents were self-administering medication.  Ten of ten medication charts reviewed identified that the GP or NP had seen the resident three monthly and the medication chart was signed. Not all medication charts indicate medication is being administered as prescribed. Not all charts sampled document the indication for giving the ‘as required’ medication or document the maximum dose for ‘as required’ medications. The previous shortfall relating to sign-off of short course medications has been addressed. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There is a rotating four weekly menu in place designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.  Food safety information and a kitchen manual are available in the kitchen. Food served on the day of audit was hot and well presented.  The residents interviewed spoke positively about meals provided and they all stated that staff ask about their food preferences.  The service has a process of regularly checking food in both the fridge and freezers to ensure it is disposed of when use by date expires. All food is stored and handled safely. Food temperatures are recorded. The kitchen is clean.  Kitchen staff have been trained in safe food handling.  Additional nutritious snacks are available over 24 hours and are readily available for residents in the dementia unit  The service can cater for an additional five residents in the dementia unit. |
| 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 | Wound care plans, turning records and ongoing pain assessments (in the hospital and rest home but not the dementia unit) were evident. The use of short-term care plans was evident. Historical medical issues that may affect present care were addressed in care plans sampled (eg, conditions causing ongoing pain, previous surgery). The sample of five residents was increased to include a further four residents (two hospital, one rest home and one dementia) around care plans. In all nine care plans sampled the care plans did not document interventions for all identified needs. Caregivers interviewed were familiar with the contents of care plans. Residents' needs are assessed prior to admission and residents’ primary care is provided by the facility GPs unless the resident chooses another GP. Falls and pressure injury assessments are completed six monthly but not reviewed when events occur. Weights are recorded monthly but weight loss is not always addressed.  Dressing supplies are available and a treatment room stocked for use.  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.  Specialist continence advice is available as needed.  Wound assessment and wound management plans are in place for six residents with 13 wounds. One resident has a grade-one pressure area (link tracer 1.3.3). Not all wounds have an individual assessment and plan and not all have been reviewed within required timeframes. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are three activities coordinators – one operates the activities programme in the dementia unit (this person has completed dementia related training) and the other in the rest home/hospital. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and dementia lounge and throughout the facility. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.  Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life.  All residents and family members interviewed stated that activities are appropriate and varied and spoke positively about the programme.  Five resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review. Residents in the dementia unit have an activity plan over 24 hours. Caregivers in the dementia unit assist with activities over the weekend and evenings. The programme observed was appropriate for older people with mental health conditions. The programme caters for an additional five residents in the dementia unit. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | PA Low | All initial care plans in files sampled were developed and reviewed by an RN. Long-term care plans are developed within three weeks of admission and evaluated at least six monthly but not always, if there is a change in health status (link 1.3.6.1, 1.2.4.3). Short-term care plans are used for acute needs. These are not always evaluated. GPs or the nurse practitioner (NP) review residents medication at least three monthly or when requested if issues arise or health status changes. |
| 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 building has a current building warrant of fitness. The five new rooms in the dementia unit are appropriate for the needs of the residents. There are sufficient toilets to accommodate the extra residents. The lounge and dining area has been doubled in size providing a large communal area, which is more than sufficient for all the residents in the unit. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The registered nurse is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly resident infection data sheet, then analysed and evaluated, and reported to staff meetings. |
| Standard 2.1.1: Restraint minimisation  Services 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 staff. There were five restraints and three enablers in use at Kenwyn on the day of the audit. Enabler files sampled demonstrated that enabler use is voluntary. |

# Specific results for criterion where corrective actions are required

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

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

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

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | PA Low | The 2013 business plan documents the mission and philosophy of the organisation. A documented review of the business plan has not been conducted. | There is no evidence of the business plan having been reviewed or updated since 2013. | Ensure that the business plan is reviewed and updated regularly.  90 days |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | A resident satisfaction survey was completed in August 2014. Fourteen surveys were returned and these all showed that residents were generally or very satisfied. The results were shared with staff at the staff meeting but not with residents or relatives. Sixteen of twenty-one internal audits were completed for 2015, the executive nurse manager reported that all either had been completed or were in progress. The audit that was stated to be in progress was documented to be completed in September 2015. The outcomes of these audits were reported at staff meetings. | (i) There was no feedback given to residents/relatives from the resident satisfaction survey.  (ii) Five of 21 internal audits had not been completed as per the 2015 audit schedule. | (i) Ensure residents and relatives are given feedback from the satisfaction survey.  (ii) Ensure all internal audits are completed as per the audit schedule.  90 days |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with the registered nurse and caregivers confirmed their involvement in the quality programme. Six completed internal audits did not identify any areas for improvement. Two internal audits had corrective action plans and the action plans had been signed off as completed. | Six internal audits and the resident satisfaction survey did not have a corrective action plan in place where areas of improvement were identified. Two audits with corrective action plans did not evidence any progression to achievement of these corrective action plans. | Ensure a corrective action plan is commenced where an internal audit or satisfaction survey identifies areas of improvement required. Ensure there is evidence of corrective actions being signed off when completed.  90 days |
| Criterion 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA High | Caregivers interviewed report that they complete an incident report if they are the person to discover the incident and then they pass it to the registered nurse. The incident report has a space for the person who reports the incident (usually a caregiver) to complete. There is a section for a doctor to complete and a small section to identify actions to prevent recurrence. This had not been completed on 37 of 39 incident forms completed. On all 39 incident forms sighted the registered nurse had signed the incident form but on 20 of the 39 forms, there was no clinical assessment documentation by the registered nurse following the incident. Ten of 20 files sampled around incidents had a progress note by a registered nurse around the incident. Neuro-observations were inconsistently completed following incidents with a knock to the head. The executive nurse manager (ENM) reports that she reviews and collates data for all incident forms at the end of the month. November 2015 incidents have not yet been reviewed (but the ENM reports they have been viewed to check for RN signature and family notification). Files sampled identified one pressure injury and four falls in November 2015 for which incident forms were not completed. | Thirty-nine incident forms were reviewed (all incidents documented for November 2015).  (i) Five incidents identified in residents’ progress notes (four falls and one pressure injury) for November 2015 did not have a corresponding incident form.  (ii) The executive nurse manager reports of not having yet collated incident forms for November 2015. No incident forms sighted documented follow-up or review by the executive nurse manager. The ENM sates she has viewed but no evidence of this through signing.  (iii) Twenty of 39 incident forms sighted for November 2015 have the incident form signed but no follow-up of the incident documented on the form by the registered nurse. Ten of these also did not have documentation by a registered nurse in the progress notes about the incidents.  (iv) Thirty-seven of thirty-nine incident forms sighted did not have opportunities to prevent recurrence identified.  Incident forms sampled included the following:  (a) A hospital resident had been challenging when mobilising so the caregiver made a decision to use a hoist. The assessment (InterRAI) and care plan did not identify hoist use. The resident sustained three skin tears.  (b) A hospital resident had sustained two skin tears while a hoist was being used to transfer the resident. Neither the recent InterRAI assessment nor the recently reviewed care plan included the use of a hoist.  (c) A hospital resident who presented as aggressive (now discharged) had grabbed a caregiver by the throat while two caregivers were present. The incident report documents that the caregiver ‘pushed’ the resident from standing position on to the bed. The caregiver was interviewed and reports that this movement had occurred as the resident was unsteady and would have fallen if suddenly let go and was not in fact a ‘push’. An RN is reported as being notified by the caregivers. The form was signed by a registered nurse. The RN had documented in the progress notes regarding the behaviour, but not the incident.  (e) A dementia level resident slapped another resident twice in the space of three days. Neither incident had been followed up on the incident form by the registered nurse (although they were signed by the registered nurse). Only the first incident was documented in the progress notes. Staff report that the resident was known to be aggressive and targets the other resident. No opportunities to prevent recurrence were identified and the care plan does not document triggers or techniques to manage the behaviour (link 1.3.6.1).  (f) A rest home resident wandered to the edge of the car park. A registered nurse signed the related incident form but did not make any other documentation on the incident form. There was no related entry in the progress notes and the care plan does not include management of this behaviour (link 1.3.6.1). | (i) Ensure all incidents are documented on an incident form.  (ii) Ensure that the executive nurse manager or a suitable representative reviews incidents regularly.  (iii) Ensure registered nurses document follow-up of the incident on the incident form and in the progress notes.  (iv) Ensure opportunities to minimise the risk of recurrence are identified for all incidents.  7 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Doctors are responsible for prescribing and all medication charts sampled have been reviewed at least three monthly by the GP. Five of ten medication charts sampled have ‘as required’ medications documented correctly. Registered nurses administer medications in the rest home/hospital and caregivers or enrolled nurses in the dementia unit. ‘As required’ medication use in dementia unit has RN oversight as the medications are locked in nurses treatment room Three of ten medication administration records sampled indicate that medications have been administered as prescribed. | (i) Five of ten medication charts sampled do not document an indication for use for ‘as required’ medication and four of ten do not have a maximum dose documented for as required medications.  (ii) Seven of ten medication charts sampled do not have all medications prescribed signed for when administered.  (iii) One bottle of eye drops in the dementia unit and one in the hospital had not been dated when opened. Two bottles in use in the dementia unit were out of date. | (i) Ensure ‘as required’ medications document an indication for use and maximum dose.  (ii) Ensure medications are signed for when administered.  (iii) Ensure that eye drops are dated when opened and discarded when expired.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Four of five residents had an initial assessment and care plan completed within 24 hours of admission. The InterRAI assessment tool is in use. One resident did not have the InterRAI assessment completed in a timely manner. | (i) One rest home resident admitted after 1 July 2015 did not have an InterRAI assessment completed within 21 days of admission.  (ii) One dementia resident file sampled did not have the initial care assessment and care plan dated. | Ensure that all residents have initial assessments and care plans and InterRAI assessments completed within the expected timeframe.  90 days |
| Criterion 1.3.3.4  The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Moderate | Progress notes in the rest home and hospital, are documented by a registered nurse at least every 24 hours and caregivers add notes when changes are observed. The caregivers or an enrolled nurse completes dementia resident progress notes. There is a lack of documented evidence in progress notes of regular registered nurse assessment and interventions or as required interventions following incidents (link 1.2.4.3) or changes in health. | Ensure that a registered nurse regularly assesses dementia residents and that changes in health status are followed up by a registered nurse and that this is documented in progress notes. | Ensure that a registered nurse regularly assesses dementia residents and that changes in health status are followed up by a registered nurse and that this is documented in progress notes.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | All resident files sampled have a pressure risk assessment and falls risk assessment (some using InterRAI) completed routinely six monthly. Risk assessments are not always reviewed when needs change. Caregivers record weights monthly and written into resident’s individual weight charts by registered nurses. One of three resident files for residents who had experienced weight loss had this appropriately addressed. Registered nurses in the rest home and hospital and caregivers or enrolled nurses in the dementia unit complete dressings. Registered nurses document wound assessments and plans. The 13 wounds at the time of the audit included eight skin tears, three surgical wounds (for one resident), one leg ulcer and one grade one pressure area. One resident with three wounds had each wound documented on a separate assessment and plan. Three other residents with more than one wound do not have a plan and assessment for each wound. One wound had been reviewed consistently within the stated timeframe. | (i) One rest home level resident with six falls documented in November 2015 has not had a falls risk reassessment completed. One hospital level resident with a recent pressure area has not had a pressure risk reassessment completed. Two dementia level residents with intermittent pain do not have ongoing pain assessments.  (ii) Two residents (one dementia level and one rest home level) with weight loss documented on the monthly weight chart, have not had this identified or any actions implemented to address this.  (iii) Nine care plans sampled (four dementia, three hospital and two rest home) did not have interventions documented in the care plan to address all identified needs. Examples included weight loss, pressure risk, falls risk, continence issues and depression.  (iv) Three residents with multiple wounds have one assessment and management plan to address more than one wound.  (v) Two of thirteen wounds do not have a timeframe for review documented. A further ten wounds have not been reviewed within the stated timeframe. | (i) Ensure risk and pain assessments are completed appropriately.  (ii) Ensure weight loss is identified and managed.  (iii) Ensure care plans document interventions for all identified needs.  (iv) Ensure that each wound has an individual assessment and management plan.  (v) Ensure the timeframe for wound review is documented and that the stated timeframes are adhered to.  60 days |
| Criterion 1.3.8.2  Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome. | PA Low | Short-term needs are documented on short-term care plans. Examples sighted included a fractured neck of femur, AWOL risk, skin breakdown, bruises, falls management and infections. Four of nine short-term care plans had been evaluated when the issue resolved. One plan was current. | Four of nine short-term care plans had not been reviewed when the issue resolved. | Ensure short-term care plans are evaluated in appropriate timeframes.  90 days |

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

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

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

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

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End of the report.