# Thorrington Village Limited – Thorrington Village

## 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:** Thorrington Village Limited

**Premises audited:** Thorrington Village

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

**Dates of audit:** Start date: 18 November 2015 End date: 18 November 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:** 42

# 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** |
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|  | 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

Thorrington Village is part of the Archer group and was acquired in June 2015. The service is certified to provide care for up to 58 residents at rest home and secure dementia level. On the day of the audit there were 42 residents; 12 in the secure dementia wing and 30 in the rest home.

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 manager is appropriately qualified and experienced. Feedback from residents and relatives is positive.

Eleven of the 18 shortfalls from the previous certification audit have been addressed. These include policies and procedures, residents’ meetings, informed consent, management education/training, appointment of a new facility manager, staff education and orientation, and risk assessments, evaluation of care, staff competencies, and food fridge temperatures.

Further improvements are required in relation to complaint management, documented communication of quality outcomes to staff, adverse events, timeliness of care planning, activities care plans, medication management and care plans reflecting resident need.

This audit has identified no further issues requiring improvement.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Some standards applicable to this service partially attained and of low risk. |

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 manager and clinical manager have 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 low risk. |

Thorrington Village has a quality and risk management system that supports the provision of clinical care and support. Key components of the quality management system link to a comprehensive action plan and reporting to senior management and resolution, there are resident/relative meetings. Incidents are documented and there is immediate follow-up from an enrolled nurse or the clinical manager (registered nurse). There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive 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.

## 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. The clinical manager (registered nurse) is responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the residents’ assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and 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 building holds a current 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. |  | Standards applicable to this service fully attained. |

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There are no restraints or enablers being used. Staff are trained in restraint minimisation and challenging behaviour management.

## 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. |

Appropriate infection control practices were observed during the audit. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, 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.

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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 | 13 | 0 | 4 | 3 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 4 | 3 | 0 | 0 |

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| **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).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The previous audit noted that not all resident files had documented written consent forms. Five resident files reviewed for this audit all had completed and signed consent forms. The service also audits this process monthly. The previous finding has been addressed. |
| 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 procedures has been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints log has been commenced that documents actions and follow up undertaken. This is an improvement from the previous audit. Three resident/family related complaints were reviewed and two staff related complaints were reviewed. Written follow-up on complaints has not been fully documented. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | New policies and procedures were introduced to the facility in July 2014. The policies and procedures align with the health and disability services standards and the DHB contract. There is a quality framework that supports an internal audit programme. Residents and families interviewed expressed satisfaction with the care and service provided. Since the previous audit, the service has implemented a process of policy signing sheets; this is documented as being implemented with the introduction of new policies from the Archer group. The previous finding has been addressed. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents (six rest home) and two dementia residents relatives interviewed stated they are informed of changes in health status and incidents/accidents. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings have commenced which is an improvement on the previous audit. The manager has an open-door policy. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.  Thirty resident related incident forms documented that family had been informed as appropriate and five resident files reviewed evidenced that either the resident or family had been consulted. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Thorrington Village, provides care for up to 58 residents at rest home level and secure dementia care. On the day of the audit, there were 42 residents in total (30 residents in the rest home and 12 residents in the secure dementia unit). The service was purchased by the Archer group in June 2015 and is managed by an experienced manager (away on day of audit). The manager is supported by a full-time, experienced clinical nurse manager (registered nurse). The Archer group also provides overarching support from a quality manager who is assisting the service to complete the transition to the Archer group processes.  There is a current business plan, and quality and risk management plans specific goals include the reduction of falls, medication errors and skin tears. The manager was away on a management course on the day of audit. This closes the previous finding around the manager completing eight hours of training relating to the management of a rest home.  The business plan documents the mission and philosophy of the organisation. |
| 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 | Since the Archer Group purchased Thorrington Village, the management team has undertaken an internal review of systems and processes. This review is collated onto a central database/action plan. The database also includes the shortfalls from the previous audit.  The service has held quality improvement (QI) meetings at least three times per month since purchase date. Quality improvement meetings document a review of the action plan and evidences that the service is proactively addressing concerns raised by both the previous external audit and its own internal review. This is an improvement on the previous audit.  Health and safety, infection control, and issues raised from monthly quality monitoring such as Incidents and accident data, are not documented as reported to QI meetings and is a continued area for improvement.  Other meeting minutes documented include monthly clinical meetings. Family and resident meetings commenced October 2015. Daily (informal) staff meetings are implemented as reported by staff and ensure staff are aware of day to day changes with new systems.  Relevant standards and legislative requirements are identified and are included in the policies and procedures manuals. Policies and procedures reflect current accepted good practice. Policies/procedures are available with systems in place for reviewing and updating the policies and procedures regularly.  The internal audit schedule from the new owners has been commenced. Areas of non-compliance identified at audits have been entered onto the central data base and are documented as having been actioned for improvement. The service has implemented a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/procedures to support service delivery. Policies and procedures align with the client care plans.  A review of the service action plan, management reporting documents and discussion with staff evidences a culture of improvement is implemented. Improvements include implementation in progress of the quality system, ACE training for staff, a new emergency flip chart and associated policies and procedures and food service monitoring.  Benchmarking has commenced since September with other Archer sites around falls, skin tears, staff accidents and urinary tract infections. |
| 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 Low | 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 30 resident related incident reports for 2015 was reviewed. Not all incident forms reviewed had been reviewed and signed off by the registered nurse.  There is a monthly collation of data undertaken by the nurse manager which includes trending and graphs. Benchmarking has commenced with other Archer sites. Medication errors are reported at clinical meetings (link #1.2.3.6).  The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise, and debriefing. Monthly and annual review of incidents informs quality initiatives.  The previous audit found that neuro-observation was not always documented. Two incident forms followed-up following a blow to the head documented neuro-observations and appropriate care documented. Five incident forms reviewed specifically to ensure follow-up in the resident file, all had appropriate documentation in progress notes and care plans. This is an improvement since the previous audit. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Five staff files reviewed evidences that relevant checks have been completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Staff turnover was reported as low. The service has a comprehensive 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. Three new staff files documented two with an orientation and one staff member in the process of undergoing a documented orientation process. Annual appraisals are conducted for all staff. This is an improvement on the previous audit.  The newly implemented in-service calendar exceeded eight hours annually and covered appropriate topics. This is an improvement on the previous audit. The clinical 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 | There is a fortnightly roster in place that provides sufficient staffing cover for the provision of care and service to residents. There is a registered nurse on duty Monday to Sunday during the day and RN on call at all times. There is also an enrolled nurse as an additional trained staff member on duty on three to four days a week. Caregivers and residents and family interviewed advised that sufficient staff are rostered on for each shift. All caregivers have been trained in first aid and CPR. |
| 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 | Medicine management policies and procedures are documented to promote a medication system which aligns with legislation and current guidelines. The service uses individualised medication blister packs which are checked in on delivery. Medication administration was observed on the day of audit as compliant. Medicines and associated documentation are stored securely and all medication checks are completed and meet requirements. Medication profiles reviewed were legible. Resident photos and documented allergies or nil known were recorded on the medication charts reviewed.  All ten medication charts reviewed have ‘as needed’ medications prescribed with an individualised indication for use. Signing sheets correspond with the medication prescription chart. Eye drops were signed and dated and used within the stated time. Progress notes record effectiveness of pain medication. An annual medication administration competency is completed for all staff administrating medications and medication training had been conducted. The service has addressed this previous finding.  Previous audit findings have been addressed relating to documentation of ‘as required’ medications, dating of eye drops and recording of effectiveness of ‘as required’ medications. Three monthly medication reviews have not consistently been completed by the attending GP, and discontinued medications are not always signed and dated.  The medication fridge has temperatures recorded daily and these are within acceptable ranges. None of the residents self-administer any medication. |
| 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 | All meals at the facility are prepared and cooked on site. There is a four weekly winter and summer menu, which had been reviewed by a dietitian. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Fridge and freezer temperatures are monitored and recorded. The previous audit finding has been addressed. Staff were observed assisting residents with their lunchtime meals and drinks. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen.  Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. Food and snacks are available 24 hours a day for all residents. The cook and kitchen staff who serves the food have received food safety training. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Personal needs information is gathered during admission. Progress notes are completed on each shift or as health care needs change. All new residents admitted since July has an InterRAI assessment completed. InterRAI is being used as the general assessment with other assessments being undertaken as clinically indicated, including but not limited to additional wound, cultural and spirituality. Reference to interviews with the resident, family and other health professionals is apparent.  Behaviours assessments and monitoring charts are used for any residents that exhibit challenging behaviours. The previous audit finding has been addressed.  Risk assessment tools were sighted as completed, reviewed at least six monthly or when there was a change to a resident’s health condition. Care plans reflected the outcome of the risk assessments for the five resident files sampled. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Five files reviewed and the long-term care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. Resident/family/whānau involvement in the care planning process was evidenced in the five resident files sampled. Residents and relatives interviewed confirmed they were involved in planning care. Care plans reflect allied health instructions for required support. Care staff confirmed they have access to care plans and informed of any changes.  InterRAI assessment, assessment summary which includes triggered CAPs, outcome scores and the needs identified by the RN informs the care plan.  Not all care plans reviewed included all identified needs and interventions to support these needs. This was a previous finding and continues to require improvement.  Two care plans reviewed in the dementia unit detail care and support for behaviours that challenge, including triggers, associated risks and management. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Five residents’ files reviewed confirm comprehensive care plans with interventions to manage the needs of the resident with exceptions (link to 1.3.5). Interviews with staff and relatives confirmed involvement of families in the care planning process. Communication with relatives was evidenced in the progress notes. Handover between shifts are comprehensive.  The clinical staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and treatment rooms are well stocked for use.  Monitoring forms in place include (but not limited to), monthly weight, blood pressure and pulse, food and fluid charts, blood sugar levels and behaviour charts. RN input is evident in progress notes. Short-term care plans were in use for changes in health status.  When a resident’s condition alters, interventions to meet the resident’s needs are developed and communicated to staff. Interviews with residents and families confirmed all care needs were met. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Moderate | The social events coordinator interviewed provides an activities programme five days a week (35 hours) and divides the time between the two units. The programme is planned monthly and residents receive a personal copy. Activities planned for the day are displayed on the central notice board. A diversional therapy plan is developed for each individual resident based on assessed needs. The residents in the dementia unit have completed activity assessments and an initial activity care plan completed that covers the 24 hour period. This previous audit finding has now been addressed. However, assessments for rest home residents files reviewed had incomplete activity assessment documentation. Five files reviewed confirmed evaluations on individual activity plans not completed six monthly with other care plan reviews.  Individual activity plans reflect triggers and specific interventions that may be helpful to assist with behaviours that challenge.  Residents are encouraged to join in group activities that are appropriate and meaningful and are encouraged to participate in community activities. Residents were observed participating in activities on the days of audit. Resident meetings provide a forum for feedback relating to activities. At interview the social events coordinator detailed visiting residents who do not participate in the group activities offering individual activities. Healthcare assistants also encourage residents to remain active and to participate in the facility’s activities.  Residents and family members interviewed discussed enjoyment in the programme and other staff provides support over weekends. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | There is a policy on care planning and includes care plan evaluation timeframes. Family interviews confirmed family were notified of any changes in their relative’s condition and also confirmed their involvement in care plan evaluations. GP interviews confirmed the RN communicates any changes of resident’s condition to them in timely manner. Short-term care plans are completed for short-term problems. This previous audit finding has been addressed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 1 July 2016). |
| 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 the infection control policy. The registered nurses described links to the DHB for assistance and health resource.  Monthly infection data is collected for all infections based on signs and symptoms of infection. Monthly rates of infection are collated and analysed (link #1.2.3.6 regarding results provided to staff). |
| 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, as evidenced in the restraint policy and interviews with staff. There are no residents requiring restraint or enablers.  There is a documented definition of restraint and enablers in the policies, which is congruent with the definition in NZS 8134.0. Enablers are voluntary. Staff have had training around restraint minimisation and the management of challenging behaviours. |

# 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 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Low | Five complaints were reviewed, all document that the complaint has been followed up and signed off on the complaints register. Two of the complaints were from staff and concerned abuse. Both complaints document a follow-up action with individual staff concerned. Families and residents interviewed agreed that the service is responsive to complaints and acts appropriately. | Two of the three resident related complaints did not document a written follow-up/letter to the complainants. Two staff related complaints around possible abuse did not include an action plan or staff follow-up around abuse and neglect training. | Ensure complaints have a documented reply to complainants. Ensure that action plans are in place to ensure that identified problems (such as possible abuse) are followed.  60 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 | The service has implemented a new quality system which includes a central database of all areas of noncompliance, actions needed and subsequent follow-up actions undertaken. Quality meetings are documented at least three times a month and evidence that the action plan is communicated to staff. | Monthly quality outcomes, such as incidents and accidents and infection control are not documented as reported to staff. | Ensure that quality meetings document the communication and discussion of all quality monitoring and quality activities.  60 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Low | Incident and accident forms are reviewed and collated monthly; the service provides a trending analysis and graphs and benchmarks the information with other sites. Thirteen of thirty incident reports reviewed had been reviewed by the registered nurse. | Seven of 30 resident related incident forms had not been reviewed and signed by an RN. | Ensure an RN reviews all resident related incidents.  60 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 | A comprehensive medication management policy is available and implemented. The medication management system is documented. The service uses individualised medication blister packs which are checked in on delivery to the facility. | i) Three medication charts did not evidence a three monthly medication review by the GP; ii) The GP had not signed and dated discontinued medication on four of ten medication charts; and iii) Expired medication has not been discarded. | i-ii) Ensure the GP completes and reviews medication documentation as per policy requirements; and iii) Discard all expired medication.  60 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 | Risk assessments are completed to ensure specific resident focused care is provided. Medical assessments and reviews were documented in all five residents’ files by a general practitioner (GP). Written comprehensive care plans were completed within three weeks for three of five resident files reviewed and three of five files evidenced that evaluations were completed within six months. | i) Evaluations of long-term care plans for one rest home resident and one dementia resident were not completed within six months; and ii) Two rest home residents long-term care plans had not been completed within three weeks of admission. | Ensure care planning and review is completed within the stated timeframes.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The following reports have been reviewed on the day of the audit: assessment summary, CAP, outcome scores and care plan. Files reviewed confirmed care plans are current, resident focussed and care outcomes reflect achievable goals. Three of five files reviewed include detailed interventions to support the current assessed needs of the residents. Two files reviewed did not identify all the current needs and interventions documented to manage the resident. | Two (rest home) of five long-term care plans did not fully reflect the current needs of the resident or include interventions to support identified issues. One resident identified as a smoker, did not have special interventions recorded to manage the habit, and another resident had recurrent episodes of high blood glucose levels which were not identified in the care plan and interventions were not documented to manage this need. | Ensure residents long-term care plan reflects the current need of the resident and the required intervention to support those needs.  30 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Moderate | Activities assessments are completed prior to activities care plans being completed. Monthly progress summaries and attendance registers are completed for all residents. | i) Activity assessment documentation for three rest home residents were not fully completed, dated and signed; and ii) Activity care plans for all five residents have not been reviewed or evaluated six monthly. | i) Ensure that activity documentation is completed as per policy, and ii) Ensure activities care plans are reviewed when the long-term care plan is due.  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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| No data to display |

End of the report.