

Social Service Council of the Diocese of Christchurch - Fitzgerald

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Social Service Council of the Diocese of Christchurch
Premises audited:	Fitzgerald Retirement Complex
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 7 January 2016 End date: 8 January 2016
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:	83

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

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

General overview of the audit

Fitzgerald Complex is certified to provide rest home, hospital and dementia care for up to 87 residents. On the day of the audit, there were 83 residents. The service is part of the Anglican Living organisation managed by an experienced registered nurse. The director of Anglican Living, an assistant manager and three unit managers support the facility manager. Family and residents interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a subset of the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, general practitioner, staff and management.

The service has addressed three of the four previous certification audit findings relating to provision of services to meet the residents assessed needs, self-medicating residents and inclusion of all infections in surveillance data. Further improvements are required in relation to aspects of medication management.

This surveillance audit identified that improvements are required in relation to reporting of pressure injuries, timeframes for completion of assessments and care plans and documentation of care plans.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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 facility manager has an open door policy.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Fitzgerald Complex 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 meetings. Incidents are documented and there is immediate follow-up from a 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. Staffing levels are monitored closely.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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 stored 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. A contracted company provides the food service. Kitchen staff are trained in food safety.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a current building warrant of fitness certificate.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

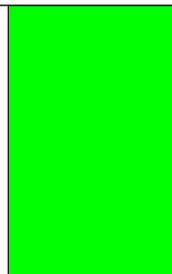


Standards applicable to this service fully attained.

There is restraint minimisation and safe practice policies applicable to the service. Guidelines on the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. The restraint and enabler register is up to date. There are currently two hospital residents with restraint and two hospital residents with enablers.

Infection prevention and control

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



Standards applicable to this service fully attained.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	2	2	0	0
Criteria	0	37	0	2	2	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](#).

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available and staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Twelve complaints were received in 2015 and review of these shows appropriate processes have been followed within the expected timeframes. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Nine residents (four from the hospital and five from the rest home) and four family members interviewed (two from hospital residents and two from dementia residents) stated they are informed of changes in health status and incidents/accidents. This was confirmed on nine incident forms sighted. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur two monthly and the managers have 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/whānau). If residents or family/whānau have difficulty with written or spoken English the interpreter services are made available.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>There is a strategic plan (2015 - 2017) for the facility, which includes a vision, a mission statement and core values and a business plan July 2015 - June 2016.</p> <p>The facility manager is an experienced registered nurse who reports to the director of Anglican Living. Fitzgerald Complex provides care for up to 87 residents across rest home, hospital and dementia service levels. On the day of the audit, there were 83 residents (27 rest home, 37 hospital residents (including 1 respite) and 19 dementia). The facility manager has completed more than eight hours of training relating to the management of a rest home. An assistant manager who is an experienced registered nurse supports her and there are registered nurses in each unit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Fitzgerald complex has a quality and education coordinator who has been in the role for five years. Progress with the quality and risk management programme has been monitored through monthly quality health and safety meetings and staff meetings. Unit managers attend these meetings and take issues back to their own areas. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff (including six caregivers [two from hospital, two from rest home, two from dementia], three unit managers and one registered nurse, the education and quality coordinator, the director, the facility manager, assistant facility manager, two activities assistants and one kitchen manager) confirmed their involvement in the quality programme. Resident meetings have been held two monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2015 has been completed. Areas of non-compliance identified at audits have been actioned for improvement. The service has a quality improvement focus. One quality improvement for 2015 was the introduction of a risk specific goal initiative to increase focus on specific adverse events identified as risk areas. One result of this initiative shows the number of incidents of bruising, unrelated to falls in the hospital area, have decreased from twelve in June to three in December.</p> <p>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 document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. The death/Tangihanga policy and procedure outlines immediate action to be taken upon a resident's death. Policy has been amended to meet InterRAI requirements. Falls prevention strategies are implemented for individual residents. Residents and relatives are surveyed to gather feedback on the service provided (with positive results) and the outcomes are communicated to residents, staff and families.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Low</p>	<p>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 resident related incident reports for 2015 were reviewed. All reports and corresponding resident files reviewed, evidence that appropriate clinical care has been provided following an incident and all have been signed off. In two of six files reviewed pressure injuries were being managed for which there had not been an incident report completed. 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 is completed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (one unit manager [RN], the activities coordinator, one registered nurse and three caregivers) and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed in excess of 10 years. 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. Annual appraisals are conducted for all staff. A two yearly rotating in-service education calendar was implemented and exceeds eight hours annually and has covered appropriate topics. The registered nurses attend external training including seminars and education sessions with the local DHB.</p> <p>A competency programme is in place with evidence of annual medication competencies for the registered nurses and senior caregivers. Core competencies are also completed for all staff relating to fire and emergency plans. The orientation programme is relevant to the dementia unit. Agency staff receives an orientation that includes the physical layout, emergency protocols, and contact details in an emergency.</p> <p>Thirteen of sixteen caregivers who work in the dementia unit have completed the required dementia training through the ACE (Aged Care Education). The other three new staff are currently completing the dementia ACE programme and have worked in the unit for less than 12 months.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Fitzgerald complex has a two weekly rotating roster in place which provides sufficient staffing cover for the provision of care and service to residents. There is a registered nurse on duty at all times, in addition to the manager who works 40 hours per week, assistant manager who works 36 hours per week and the quality and education coordinator who works 40 hours per week. Caregivers, residents and family interviewed advised that sufficient staff are rostered on for each shift.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The service uses four weekly blister dose medication packs for all residents at Fitzgerald Retirement Complex. There is a signed agreement with the supplying pharmacy. The blister packs are checked and reconciled against medication charts upon arrival to the facility and signed off when the check has been completed.</p> <p>There are three medication trolleys, which are stored securely when not in use. Medication fridge temperatures are monitored daily.</p> <p>The service has a policy and procedure on residents who wish to self-medicate that includes three monthly assessments by GP of the resident's ongoing ability to safely self-medicate and a resident competency review form. Currently there is one hospital resident self-medicating inhalers at Fitzgerald Retirement Complex. The resident has been assessed as competent by the GP and reviews are conducted. The service has addressed this previous finding.</p> <p>Two medication rounds were observed and it was evidenced that staff are following the correct administration procedure. Staff education in medicine management has been provided. Twelve medicine charts were sampled. All 12 charts demonstrated residents' photo identification. Weekly checks of controlled drugs is undertaken. All 12 charts evidence completed corresponding signing sheets and all charts had indications for use recorded for 'as required' medications. The service has addressed these aspects of the previous findings. Medication reconciliation has been completed on admission by a registered nurse. Not all treatments being provided are prescribed and medication documentation is not fully completed for all areas of medication management. There were expired medications noted in use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p>	<p>FA</p>	<p>All meals for Fitzgerald Retirement Complex residents are prepared and cooked on site by a contracted company. Kitchen staff are trained and qualified in safe food handling. Meals are served directly to the rest home from the bain marie in the kitchen. The hospital and the dementia unit meals are transported on a trolley and served from bain maries.</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>A four weekly rotating summer and winter menu has been approved by a registered dietitian. Registered nurses inform the kitchen regarding resident's dietary requirements, which include likes and dislikes, modified diets and preferences. The unit managers interviewed described the process for management of residents with unexplained weight loss or gain, including referral to a dietician and speech language therapist, as required. Documentation reviewed showed monthly monitoring of individual resident's weight. Care plans include dietary requirements and are reviewed on a regular basis, as part of the care plan review.</p> <p>Additional snacks are available for residents when the kitchen is closed. Residents interviewed were satisfied with the food service provided, and report their individual preferences are well-catered and adequate food and fluids are provided.</p> <p>Food temperatures, fridge, chiller, freezer temperatures and frozen food temperatures are recorded on arrival to the facility (sighted).</p> <p>Kitchen services audits were completed. The service provides special equipment such as utensils, lip plates and sipper cups as required.</p> <p>The kitchen pantry has extra food stores - enough for three days if required in an emergency, including adequate water supply.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The scope of the audit was extended to include this standard. Registered nurses develop residents' care plans. InterRAI assessments are being completed, however, had not been used in the development of the long-term care plans for all resident files reviewed. Not all care plans in the sample reviewed were comprehensive or consistent with the assessed resident's needs. Resident's previous health history and medical risk management plans were included in the care plans. Activities assessments and care plans are documented with the exception of 24-hour activities plans for dementia residents. Residents' files are integrated. Progress notes are maintained on a daily basis. A multidisciplinary approach to care is evidenced in residents' files reviewed. Staff communicate during each shift handover. Residents and family members interviewed were happy with the care provided</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>FA</p>	<p>The care being provided for rest home, hospital and dementia care was consistent with the needs of the resident as evidenced through documentation review and interviews with residents and families. Relatives are notified of changes in a resident's condition. The registered nurses initiate a GP or specialist consultation for any changes in resident health status. Staff document any changes in care/condition of residents in the progress notes. All residents and family/whānau interviewed reported satisfaction with the care and service delivery.</p> <p>Monitoring forms were in use for turning bed-ridden residents, food and fluid intake charts, behaviour monitoring, and restraint monitoring. Wound care assessments and care plans were comprehensive and wound care has been completed within the required timeframes for the residents with wounds. Neurological observations have been</p>

desired outcomes.		<p>conducted for residents who sustain a suspected head injury. The service has addressed the previous findings. Specialist reviews and recommendations were implemented. There were adequate dressing and continence supplies sighted on the day of audit.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There are five activities staff at Fitzgerald retirement complex. Two staff provide activities in the dementia unit seven days a week. One staff member facilitates the rest home activities programme and two staff provide activities to hospital residents. Activities staff have either the ACE qualifications or are working towards achievement of these. The four activities staff interviewed reported that they modified the programme related to the response and interests received from residents. Resident's capability and cognitive abilities were considered in planning of the activities program. The activities programme covers physical, social, recreational and emotional needs of the residents.</p> <p>Fitzgerald Retirement Complex has a van and regular outings are provided. Activities care plans are completed (link #1.3.5.2) and evaluations are completed when care reviews occurred. Residents and families interviewed confirmed that the programme included interests of individuals and points of interest in the community.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Initial care plans reviewed had been evaluated within three weeks of admission where these have been recorded (link #1.3.5.2). Long-term care plans had been evaluated at least six monthly and they were all outcome or goal focused. The InterRAI outcome assessment is used as part of the evaluation process. The GPs examine residents monthly or if the resident is stable then at least three monthly. Three monthly medication reviews were evident in the sample of medication charts reviewed. Where progress was different from expected, the service responded by initiating changes to the long-term care plan. Files reviewed had evidence of changes in the care plan interventions as required. The family/whānau interviewed reported high satisfaction with the care provided at the service.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The two buildings (rest home and hospital/dementia) each have a current building warrant of fitness.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in Fitzgerald Retirement Complex's infection control manual. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at infection control meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There has been no outbreaks.</p> <p>There was a previous finding that infections not being treated were not included in surveillance data. This finding has now been addressed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is restraint minimisation and safe practice policies applicable to the service. Guidelines of the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register. There are currently two hospital residents using restraint and two hospital residents with enablers. Documentation was reviewed for one restraint and one enabler and evidences assessment, authorisation, consent, planning, monitoring and review of the devices.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service</p>	PA Low	Any staff who are aware of an incident, document this and involve the RN by a process. The report is then followed up by the unit manager and sent electronically to the facility manager for completion. The quality and education coordinator then captures trends and these are discussed and implemented at the quality health and safety meeting. In two of six files reviewed there were pressure injuries being managed for which there had not been an incident report completed.	Two current pressure injuries (both hospital) had not been reported via the incident reporting process.	<p>Ensure all pressure injuries are reported via the incident reporting process.</p> <p>90 days</p>

delivery, and to identify and manage risk.				
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Registered nurses administer medications in the hospital, and senior caregivers administer medications in the rest home unit and dementia unit. There is a list of staff competencies maintained in the education folder and all staff administering medications have passed their competency. Twelve medicine charts were sampled (four from each service level). All 12 charts had residents' photo identification. Medications are stored appropriately and medication rooms were kept locked when not in use. Allergies were documented on nine of twelve charts. Three monthly reviews were evident for all charts reviewed. Controlled drugs are securely stored and weekly checks are conducted. Signatures in the controlled drug register in the rest home were incomplete. Advised by the unit managers that there is a system in place to check for expired medications and these are returned to the pharmacy, however, expired medications were found in the hospital and rest home. Oxygen therapy provided for one resident was not prescribed.</p>	<p>i) Two hospital and one dementia medication charts did not have allergies documented. ii) Three GTN spray bottles (two in the hospital and one in the rest home) were noted to have expired. iii) One rest home resident receiving oxygen therapy does not have this prescribed or recorded on the medication chart (this was addressed on the day of audit); and iv) two entries in the rest home controlled drug register had signatures missing – one entry had no staff signatures and one had one signature only.</p>	<p>i) Ensure that medicine allergies are documented on the medication charts. ii) Ensure that all expired medications are disposed of. iii) Ensure that all resident treatments requiring prescriptions have this recorded on the medication chart; and iv) ensure that all controlled drug register entries are signed appropriately.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning,</p>	<p>PA Low</p>	<p>Registered nurses develop, maintain and review care plans. Care plans are developed in consultation with residents and family/whānau where appropriate for five of six files reviewed. Initial assessments were completed within 24 hours of entry to the service for five residents (link #1.3.5.2). The InterRAI assessment tools have been completed within 21 days of entry to the</p>	<p>i) Two hospital and one rest home resident had not had the InterRAI assessment tool completed within 21 days of admission; ii) two hospital residents had not had their long-term care plan developed within 21 days of admission.</p>	<p>i) and ii) Ensure that all aspects of assessments and care planning are completed in a timely manner.</p>

<p>provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>service for three of six files reviewed. The long-term care plan has been developed within 21 days of admission for four of the six resident files reviewed. Care plan evaluations were completed at least six monthly or earlier if care needs changes. Medical reviews were completed at least three monthly but more frequent reviews were noted in the resident's file.</p>		<p>90 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Six resident files were reviewed. One hospital and two dementia resident files evidenced that care plans for these residents were comprehensive and were based on the completed assessments. Risk assessments are being used in conjunction with the InterRAI assessment tool and include falls risk, pressure injury risk, nutrition, pain, continence and challenging behaviours. Residents in the dementia unit do not have a 24-hour activities plan documented. Four of five resident files evidence an initial assessment and care plan. Short-term care plans were in use for acute issues.</p>	<p>(i) Five of six care plans did not have interventions fully documented to meet all current needs. (a) One hospital resident with leg oedema and resulting serious ooze did not have this recorded in the long-term care plan, however the progress notes did record the cares being provided. (b) One rest home resident with specific cultural needs and identified links to the community did not have this fully documented. (c) One rest home resident with dementia and a tendency to wander and mobilise unsafely, did not have interventions for monitoring and supervision recorded in the long-term care plan. (d) Two dementia resident files reviewed did not have interventions documented on how behaviours are best managed over a 24-hour period or a full description of activities to best meet the needs of the resident over the 24-hour period.</p> <p>(ii) No initial assessment or initial care plan was developed for one resident (dementia unit) who transitioned from respite care to permanent care.</p>	<p>(i) Ensure all care plans comprehensively record interventions to support the residents' care requirements. Ensure that all dementia residents have an activities plan in place, which covers the 24-hour period; and (ii) Ensure that all new admissions have an initial assessment and care plan developed.</p> <p>60 days</p>

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

No data to display

End of the report.