

Albany Rest Home 2004 Limited

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:	Albany Rest Home 2004 Limited	
Premises audited:	Albany House	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 11 January 2016	End date: 12 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:	19	

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

Albany Rest Home is a privately owned home in Gore. One owner is the nurse manager and the other owner provides maintenance and financial management support. Registered nurses and care staff support the nurse manager. The service provides rest home and hospital level care for up to 25 residents with 19 residents accommodated on the day of audit. Care staff turnover is reported as low. 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 five of eight previous certification audit findings relating to obtaining informed consent, providing mandatory education, training for the infection prevention and control coordinator, ensuring senior staff have a current first aid certificate, monitoring of enablers and calibration of medical equipment.

Further improvements are required in relation to documenting communication with families, ensuring timeframes are adhered to for assessments and care planning, and ensuring risk assessments are completed for identified resident needs.

The previous partial provisional audit conducted at certification audit, identified three findings relating to provision of chair scales for non-ambulatory residents, newly appointed staff to receive orientation/induction and medication competencies prior to occupancy of hospital level care residents. The service has addressed these findings.

This surveillance audit identified that improvements are required in relation to completing the annual audit schedule, completing annual staff appraisals, aspects of care planning, and medication documentation and management and staff competencies.

Consumer rights

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

Complaints are actioned and include documented response to complainants should the need arise. There is a complaints register.

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.
---	--	---

A business plan, quality assurance and risk management plan has been implemented for 2015 and a new programme is being developed for 2016. Policies and procedures have been reviewed to reflect the activities of the service and align with current guidelines and legislation. Quality activities are conducted and this generates improvements in practice and service delivery. Corrective actions are identified, implemented and followed when generated. Feedback is sought from residents and families. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are appropriately managed with reporting to staff evident in meeting minutes reviewed. An orientation programme provides new staff with relevant

information for safe work practice. Human resource policies are in place to determine staffing levels and skill mixes. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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>
---	--	---

Registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care provided is consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are stored securely. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. 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>
---	--	---

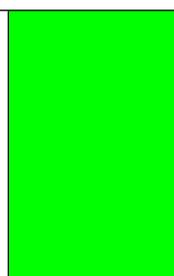
The service displays a current building warrant of fitness.

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.
---	---	--

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There are two residents with enablers and no restraint.

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. Infection rates are low and no outbreaks have been reported since the previous audit.

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	14	0	4	3	0	0
Criteria	0	35	0	6	4	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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The previous audit identified that the service had been utilising social media forums to promote the facility and to keep family and residents aware of activities in the home. The service had not obtained written informed consent from residents for the use of photographs and identifiable information. The service has since obtained written consent or decline from residents regarding the use of their photograph and information for use on social media. Informed consent is also obtained for service delivery, medical care, outings and photographs in the home. Advised, that the social media forum is no longer actively utilised. The service has addressed this previous finding.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected,</p>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission through the information pack. Complaint forms are available. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is available. No complaints have been received in the past two years. Advised by the nurse manager that any concerns or issues are dealt with immediately. There are procedures and associated documentation to appropriately manage any complaints, should they be received. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>

and upheld.		
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>Five residents (four rest home and one hospital) and three family members (one rest home and two hospital) 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 given time and explanation about services and procedures. Communication with family members has not been recorded on the sample of incident and accident report forms reviewed or in the resident daily progress notes. This previous finding remains an improvement. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Interpreter services are provided if residents or family/whānau have difficulty with written or spoken English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Albany House is privately owned with one owner in the role of nurse manager. The owners have owned Albany House for the past 12 years. Albany House is certified to provide rest home and hospital level care to up to 25 residents with 19 residents accommodated on the day of audit. The service has 19 rooms that are appropriate to provide either rest home or hospital level care. On the day of audit, there were 14 rest home residents and five hospital residents. There were two respite rest home residents and no residents under the medical component.</p> <p>The owners of Albany House have a current strategic/business plan in place. The service has a quality and risk management system with associated policies and procedures provided and updated by an external consultant. The quality plan includes objectives, policies and procedures, implementation, monitoring, quality risk, and action plan.</p> <p>The nurse manager has maintained at least eight hours of professional development in the past 12 months.</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>	PA Low	<p>The service has an established quality and risk system that includes analysis of incidents, infections and complaints, internal audits and feedback from the residents. Albany House monitors progress with the quality and risk management plan through quality/staff meetings.</p> <p>There is an internal audit schedule, however, this was not fully completed in 2015. Areas of non-compliance identified through quality activities are documented as corrective actions, implemented and reviewed for effectiveness. The service has 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.</p> <p>The service has comprehensive policies/procedures to support service delivery, which have been reviewed. Policies and procedures align with the resident care plans and have been updated to include reference to the InterRAI assessment tool. There is a document control policy that outlines the system implemented whereby all policies and procedures are reviewed regularly. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident</p>

		incidents and accidents as well as staff incidents/accidents and provides follow up where required. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Residents are surveyed each year with positive responses to all aspects of the care and services provided.
<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>	FA	<p>Incident and accident data is collected and analysed and reported to staff. All incident reports for November and December 2015 were reviewed and evidence that all adverse events were documented to manage risk. Appropriate care and support has been provided by care staff and registered nurses post incident and this is well recorded on the reports reviewed and in the corresponding resident files. Incidents and accident data is communicated to staff as evidenced in meeting minutes reviewed and staff interviews. The nurse manager is aware of her responsibilities to notify appropriate authorities when required.</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>	PA Low	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates are kept. There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Six staff files were reviewed, including two registered nurses employed since the service commenced providing hospital level care. Other files included two caregivers, one caregiver/activities person and one registered nurse. Job descriptions were not evidenced in all files reviewed. Four registered nurses have been employed to cover the roster since the commencement of hospital level care. The nurse manager covers the morning shift from Monday to Friday. The service has addressed the previous partial provisional audit findings.</p> <p>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 have not been conducted for all staff. The in-service programme for 2015 exceeded eight hours annually. The nurse manager and registered nurses have attended external training. The service has addressed this aspect of the previous certification audit finding.</p>
Standard 1.2.8: Service	FA	Albany House has a roster in place, which ensures that there is at least one registered nurse (RN), and one

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>caregiver on duty at all times. The nurse manager provides on-call. The nurse manager works full time and covers the morning RN shift Monday to Friday. Caregivers and residents interviewed advised that sufficient staff are rostered on for each shift. All care staff are trained in first aid. Residents and families interviewed advised that there is sufficient staff on duty to provide the care and support required.</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 individualised medication packs, which are checked in on delivery. The nurse manager was observed administering medications and followed the correct process. Registered nurses are responsible for administering medications. Medication competencies for registered nurses are overdue for annual review. Medication management training has been provided. Medications and associated documentation were stored safely and securely. Medication reviews have not been conducted three monthly by a general practitioner (GP) for all residents as per the medication charts reviewed. Resident photos are current and documented allergies are recorded on all 11 medication charts reviewed. Medications requiring frequent checks have not been monitored as per requirements.</p> <p>There is a self-medicating resident's policy and procedures in place. There are no residents self-administering medications. Individually prescribed and fully completed resident medication charts are not evident for all residents. Medication administration signing sheets were completed. All medication charts reviewed record an indication for use for 'as required' medications.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at Albany House are prepared and cooked on site. The kitchen is able to cater comfortably for all residents in the home. There is a winter and summer menu, which has been reviewed by a dietitian. Meals are prepared in an equipped kitchen adjacent to the dining room and served directly to the residents. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. 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 and any changes are communicated to the kitchen. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required. Resident surveys are conducted, which provides a formal opportunity for resident feedback on food services. Residents and family members interviewed indicated satisfaction with the food service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs,</p>	<p>PA Moderate</p>	<p>The previous certification audit identified that not all residents had appropriate risk assessments completed. Five resident files were reviewed and gaps in assessments continue to be a shortfall. The InterRAI assessment tool has not been utilised for all new admissions after the 1 July 2015 and not all risk assessments have been</p>

support requirements, and preferences are gathered and recorded in a timely manner.		completed as required.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	This scope of the audit was extended to include this standard in response to findings identified in resident files reviewed. Not all resident files reviewed evidenced that care plans included all required documented interventions. Activities plans were not evident in all files reviewed. Long-term care plans were not documented for all residents. Those residents with completed care plans evidenced that files were integrated and that all care staff were responsible for documenting progress notes. Wound care plans were available if required.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Long-term care plans (where completed) were current and interventions reflect the assessments conducted with exceptions (link #1.3.5.2). Interviews with the nurse manager and caregivers and residents evidence residents input. Dressing supplies are available and adequately stocked for use. Documentation for wound assessment, treatment, frequency of dressings and evaluations is available. There were no residents with wounds. The nurse manager advised that they have access to external wound support as required. Specialist continence advice was available as needed and this could be described. Monitoring forms in place include (but not limited to) weight, blood pressure and pulse, food and fluid charts and blood sugar levels. Monthly weight monitoring is conducted for all residents or more frequently as require, as evidenced in the files reviewed.
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	FA	The activities coordinator provides an activities programme over five afternoons each week with care staff providing activities over Saturday and Sunday. Activities are planned in conjunction with residents. An activity plan is developed for each individual resident based on the resident's social history and assessed needs (with exceptions link #1.3.5.2). The activity plans completed were reviewed at the same time as the care plans in resident files sampled. Residents are encouraged to join in activities that were appropriate and meaningful and to participate in community activities. The service has a van used for outings. Residents were observed participating in activities on the day of the audit. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.

service.		
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations are comprehensive as evidenced in the sample of files reviewed and reflect changes to the care plan after evaluations were completed. Short-term care plans have been utilised for residents with acute health changes with one exception (link #1.3.5.2). Any changes to the long-term care plan are dated and signed. The RN had evaluated initial care plans (sighted).
<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	Albany House displays a current building warrant of fitness, which expires on 3 June 2016. The service has had all medical equipment checked, serviced and calibrated including thermometers, blood pressure machines and stand-on scales. New chair scales have been purchased and these have been checked and calibrated. The service has addressed this previous partial provisional audit finding.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	The previous certification audit identified that not all shifts were covered with a trained first aider. All care staff have completed first aid training in either 2014 or 2015. There is at least one trained first aider on every rostered shift. Fire drills and emergency management training has been provided in 2014 and 2015. New staff receive training in fire and emergency management as part of their orientation. The service has addressed this previous finding.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the</p>	FA	The previous certification audit identified that the infection control nurse had not attended infection control training to maintain best practice. The nurse manager is the infection control nurse with support from an RN who maintains surveillance documentation. The nurse manager has completed an on-line training course in infection prevention and control in 2015. The previous finding has now been addressed.

infection control programme and meet the needs of the organisation.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection prevention and control policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. The nurse manager is the infection control nurse with assistance from an RN. 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 facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually. Infection control education has been provided in 2015. No outbreaks have been reported since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Documented systems are in place to ensure the use of restraint is actively minimised. The facility was not utilising restraint on the days of audit. Two hospital residents have enablers in the form of bedrails. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Restraint use is reviewed at staff meetings. Enabler documentation reviewed for two files included assessment, consent, authorisation, care planning and monitoring. The service has addressed this previous finding.</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)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Incident forms for the past two months were reviewed. Family are recorded as having been notified in four of the seven forms and associated resident files reviewed.	Three of seven incident forms and related resident files did not evidence that family/next of kin had been notified following an incident or accident	Ensure that family are informed of resident's incidents and accidents and that this is documented. 90 days
Criterion 1.2.3.6 Quality improvement data are collected,	PA Low	Quality activities conducted include surveys, complaints processes, resident and staff meetings and quality improvements. There is an	Internal audits around resident files, medication management and restraint were not completed in 2015.	Ensure that all internal audits are conducted as per the schedule to

analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.		internal audit schedule, which is in place each year. Internal audits completed in 2015 included staff education, hydration and nutrition, cleaning, safety and environment, admission procedures and infection control. Not all scheduled audits were completed.		identify opportunities for improvement. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	All staff files reviewed included orientation documentation, employment processes, and reference checks, however, job descriptions were only evidenced in one of files. Recruitment policies and procedures are followed and reference checks are obtained.	Five of six staff files reviewed did not evidence a signed job description.	Ensure that a signed job description is completed for each individual staff member. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Education records were reviewed for 2015. Education is provided for caregivers and registered nurses. Annual staff appraisals have been completed in one of six staff files reviewed.	Annual staff appraisals were last completed in July 2014 in three of six staff files reviewed. Two of six staff had not had an appraisal conducted since they commenced employment in 2014.	Ensure that all employees have an annual appraisal completed as per the ARC contract requirements. 90 days
Criterion 1.3.12.1	PA Low	All medications are stored	Weekly controlled drug stock checks were not conducted in	Provide

<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>securely. Weekly checks have been identified by the service as not having occurred in November and December 2015. The service has instigated a system of checking to ensure that staff conducts weekly checks of controlled drug medications.</p>	<p>November and December 2015.</p>	<p>evidence that weekly checks of controlled drugs is occurring.</p> <p>90 days</p>
<p>Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Low</p>	<p>Registered nurses are responsible for administering medications to all residents. Education has been provided in 2015. Annual medication competencies were last completed in November 2014. All registered nurses were due for review in November 2015.</p>	<p>Annual medication competencies for registered nurses have not been conducted. Competency assessments were due for completion in November 2015.</p>	<p>Ensure all staff with medication administration responsibilities are assessed as competent on an annual basis.</p> <p>90 days</p>
<p>Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to</p>	<p>PA Moderate</p>	<p>Medication charts and associated documentation were reviewed for 11 residents. General practitioners review residents' medications at least three monthly as evidenced in eight</p>	<p>i) One hospital resident and one rest home respite resident did not have a signed medication chart in place. The service was utilising hospital discharge letters with a list of medications in use. Blister packs in use corresponded with the discharge medication lists, however, these were not signed orders. ii) One hospital resident's medication chart orders were not individually signed.</p>	<p>Ensure that all medications administered are accompanied by a completed</p>

consumers at a frequency and detail to comply with legislation and guidelines.		of 11 charts reviewed. Medication charts were not in place for all residents. Hospital discharge letters listing medications were in use as a medication order for two residents. Not all medications in use had a corresponding order in place.		medication chart and individually signed medication orders. 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 Moderate	Care plans were completed for four of five resident files reviewed (link #1.3.5.2). The InterRAI assessment tool has been completed in a timely manner in three of five resident files reviewed. Long-term care plans have been reviewed within the required timeframes for two of five resident files sampled (three not yet due). Initial assessments and initial care plans have been developed for four of five resident files sampled	i) One rest home resident had the long-term care plan written 10 weeks after admission. ii) One rest home resident has not had risk assessments reviewed six monthly and iii) Two residents (one hospital and one rest home) had the InterRAI assessment tool completed after 21 days of admission.	i)-iii) Ensure that all aspects of care planning including assessments and development of long-term care plans, are completed within the required timeframes. 60 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are	PA Moderate	The InterRAI assessment tool has been completed for three of five residents (one respite rest home resident not required).	i) One hospital resident did not have risk assessments completed for falls, continence or pain and the initial assessment was incomplete. ii) One rest home respite resident had an incomplete initial assessment, the dietary profile was incomplete and continence and nutritional assessments were not completed. iii) One rest home resident had no continence or pain assessments completed, pressure risk and nutritional assessment were last completed 12 months prior and assessments had not been	Ensure that all residents have appropriate assessments completed (including InterRAI) on which to base

documented to serve as the basis for service delivery planning.			reviewed at care plan review time. iv) One rest home resident had no continence or nutritional assessment completed. v) One hospital resident admitted since 1 July 2015 had not been assessed with the InterRAI assessment tool, no initial assessment had been completed, the dietary profile was incomplete, and no risk assessments had been completed for falls, pressure, pain, continence or nutrition.	the service delivery plan. 30 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	Initial care plans were evident in two rest home resident files. Activities plans were evident in two rest home resident files. Long-term care plans were recorded for three of five residents (one respite). Care plans and assessments reviewed were not fully completed.	i) One hospital resident had no initial care plan recorded, nutrition and pain management interventions were not documented, and no short-term care plan was documented for an infection. ii) One rest home respite resident had no initial care plan. iii) One hospital resident had an incomplete initial care plan and a long-term care plan had not been developed (resident admitted in November 2015). iv) There were no documented activities plans for two hospital and one rest home residents.	Provide evidence that all residents have care plans documented for all assessed needs including initial, short-term, activities and long-term care plans. 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, 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.