

Patrick Ferry House 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:	Patrick Ferry House Limited
Premises audited:	Patrick Ferry House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 January 2016 End date: 19 January 2016
Proposed changes to current services (if any):	The service has been assessed as able to provide hospital (medical) level of care.
Total beds occupied across all premises included in the audit on the first day of the audit:	71

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

Patrick Ferry House is privately owned and operated. The service is certified to provide rest home and hospital level care for up to 74 residents. On the day of the audit, there were 71 residents. This audit has assessed the service as able to provide hospital (medical) level of care.

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 general manager and newly appointed hospital manager are appropriately qualified and experienced. They are supported by a newly appointed clinical manager. Feedback from residents and relatives is positive.

Four of the seven shortfalls from the previous certification audit have been addressed. These were around notifying family of incidents, reference checking, GP reviews and management of environmental hazards. Improvement continues to be required around complaint management, corrective action planning and aspects of medication management.

This audit has identified areas requiring improvement around policies, interRAI assessments, pressure injury prevention and management and pain assessments.

Consumer rights

<p>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.</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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Residents and relatives are aware of the process to lodge a complaint and complaints are documented. Residents and family are well informed including of changes in residents' health. The general manager, hospital manager and clinical manager have an open door policy.

Organisational management

<p>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.</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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Patrick Ferry House 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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The registered nurses are responsible for resident assessment, care plan development and evaluations within required timeframes. The residents' needs, outcomes and goals are developed in consultation with the resident and/or family. Resident files included medical notes and notes of other visiting allied health professionals.

The diversional therapist and activity coordinators provide an interesting and varied activities programme that meets the recreational needs for the rest home and hospital residents. The programme includes outings and community involvement.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete annual education and medication competencies.

All meals are prepared on site. Individual and special dietary needs are catered for and alternative options are available for residents with dislikes. The menu has been reviewed by a dietitian.

Safe and appropriate environment

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.
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The building holds a current warrant of fitness and hazards are identified and addressed.

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.
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A restraint policy includes comprehensive restraint procedures. A documented definition of restraint and enablers aligns with the definition in the standards. There are 12 residents using restraints and no enablers being used. Staff are trained in restraint minimisation and challenging behaviour management.

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.
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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.

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	11	0	0	4	1	0
Criteria	0	33	0	3	3	1	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

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>	<p>PA Moderate</p>	<p>The 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 folder has been maintained but a complaints register has not been. Twelve complaints were received in 2015 and review of these shows appropriate processes have been followed within the expected timeframes for five of the twelve. This previously identified shortfall continues to require improvement. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p> <p>Health CERT requested follow-up in this audit around a now closed complaint to the Health and Disability Commissioner around communication and medication management. This audit identified that there are effective communication processes and syringe drivers are appropriately managed when in use. Other areas of medication management require improvement.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>FA</p>	<p>Six residents (three from the hospital and three from the rest home) and five family members interviewed (two rest home and three hospital) stated they are informed of changes in health status and incidents/accidents. This was confirmed on 13 incident forms sighted and is an improvement since the previous audit. Residents and family members also stated they were welcomed on entry and 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</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>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 has difficulty with written or spoken English, interpreter services are made available.</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>	<p>FA</p>	<p>Patrick Ferry House is one of two facilities owned by the owners and provides care for up to 74 residents at rest home and hospital level care. On the day of the audit, there were 16 rest home level residents and 55 hospital residents. This included three residents on short term respite care (two rest home level and one hospital level), two on short term DHB interim care contracts and two hospital level residents funded by ACC. All rooms are dual purpose. This audit has assessed the facility as able to provide hospital (medical) level of care. The service is overseen by a general manager (who covers both facilities) and a newly appointed hospital manager and clinical manager, both of who are still undergoing orientation. Both are registered nurses and experienced health managers. The current business plan and quality and risk management plans have been implemented. The general manager has completed in excess of eight hours of training relating to the management of a rest home in 2015.</p> <p>The business plan completed in March 2015 documents the mission and philosophy and goals of the organisation. It includes a review of the previous goals.</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>	<p>PA Moderate</p>	<p>Progress with the quality and risk management programme has been monitored through monthly staff meetings. Meeting minutes have been maintained and staff are expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff (including four caregivers, two registered nurses, two activities staff and the cook) confirmed their involvement in the quality programme. Resident meetings have been held three monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2015 has been implemented. Internal audits have been completed according to the documented schedule. Areas of non-compliance identified at audits have not all consistently been actioned for improvement. This is a previously identified shortfall that continues to require further 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 policies/procedures to support service delivery but these do not include pressure injury prevention or management (link 1.3.6.1) or interRAI requirements. 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. 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</p>

		families.
<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 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 couple of outbreaks in 2015 were appropriately notified to the relevant authority. A sample of 13 resident related incident reports for December 2015 was 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. Pressure injuries have been reported via the incident reporting processes. 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>	FA	<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. Five staff files were reviewed (two healthcare assistants, one registered nurse, one cook and one activities coordinator) and included all appropriate documentation including reference checks for staff employed since the previous audit. This is an improvement since the previous audit. 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. Annual appraisals are conducted for all staff. An 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 and the hospice. Staff training records and staff interviewed provide evidence that staff are qualified to provide hospital (medical) level care.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	FA	<p>Patrick Ferry House has a weekly 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 hospital manager and clinical manager who each work 40 hours per week. Caregivers, residents and family interviewed advised that sufficient staff are rostered on for each shift.</p>

timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		
<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>	PA Moderate	<p>Medication policies align with accepted guidelines. This is an improvement since the previous audit. The RNs responsible for the administration of medications have completed annual competencies that include administration for oral, subcutaneous, intramuscular, controlled drugs and syringe driver medications. Three of the facility owned syringe drivers had not had an annual calibration check were not calibrated at the time of the audit. Healthcare assistants on night shift have completed competencies for the checking of controlled drugs. The previous finding around weekly checks of controlled drugs has been addressed. Medications are checked on arrival by the registered nurse and any pharmacy errors recorded and fed back to the supplying pharmacy. Not all eye drops in use had been dated on opening.</p> <p>There were no self-medicating residents. Standing orders had not been reviewed annually. Verbal orders had been signed off by the GP at the next visit as identified on the verbal order form. Warfarin doses have been authorised by the GP. The previous finding around verbal orders and warfarin charting has been addressed.</p> <p>Twelve medication charts and administration signing sheets were reviewed. Not all medication charts included photo identification, allergy status and indications for use of as required medications. The previous finding around photos in regards to names and dates has been addressed.</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>	FA	<p>All food is prepared and cooked on-site. There is a qualified chef and a cook who cover the seven day week. Kitchen staff have completed on-line food safety units. Staff have completed chemical safety training. There is a four weekly seasonal menu that has been reviewed by a dietitian. The cook receives resident dietary profiles and is notified of any dietary changes and requirements. Dislikes are known and accommodated as confirmed in resident interviews. Cultural and spiritual dietary requirements are met.</p> <p>Food is delivered in a bain Marie to the upstairs kitchenette. Both dining rooms have a first and second meal service ensuring those requiring additional assistance have their dignity maintained and meals served at an acceptable temperature. Fridge and freezer temperatures were recorded daily. Food temperatures had been taken and recorded daily. All foods were date labelled and stored correctly.</p>
Standard 1.3.6:	PA High	When a resident's condition alters, the registered nurse initiates a review and if required, arranges a GP visit. There

<p>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>is evidence of one to three monthly medical reviews or earlier for health status changes. Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Families confirmed they were kept informed of any changes to resident's health status. Resident files reviewed included a relative communication form with evidence of family notification such of falls, infections, medication changes, GP visits and changes to health status</p> <p>Staff report there are adequate continence supplies and dressing supplies. On the day of the audit supplies of these products were sighted. There were five skin tears, one minor superficial wound, one chronic venous ulcer and two pressure injuries on the day of audit. Wound assessments and pressure injury prevention and management are not sufficiently documented or implemented.</p> <p>Registered nurses interviewed could describe how to access the wound nurse, continence nurse and dietitian.</p> <p>Pain assessments have been completed and reviewed six monthly for long term residents who identify pain. There has been no pain assessment on admission for one resident on interim care.</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>The service employs an activity of team of three (one diversional therapist (DT) and two activity coordinators completing DT training) to coordinate and implement the integrated rest home/hospital activities programme. The programme is delivered Monday to Friday and includes a variety of interesting activities that residents report as interesting and meaningful to them.</p> <p>Residents and families have the opportunity at meetings and during discussion to provide suggestions for activities, entertainment and outings. Van trips are scheduled twice weekly and a mobility taxi is hired for those who require wheelchair transport. The activity team all have a current first aid certificate. Residents are encouraged to maintain links with community groups such as RSA visits and fellowship groups</p> <p>Residents attend church services on site and are supported to attend church in the community.</p> <p>Residents have an activity assessment completed on admission. Activity plans were sighted in the resident files reviewed. Activity plans had been reviewed at the same time as care plans.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	FA	<p>Initial nursing assessments for long term residents have been evaluated by the RN within three weeks of admission in four of four long term resident files sampled. InterRAI assessments have been commenced as the six monthly care plan falls due or earlier due to changes in health status. Team approach six monthly written evaluations demonstrate multidisciplinary input from the GP, physiotherapist, RN, activity team and healthcare assistants. The families are invited to attend the MDT meeting. Evaluations indicate if resident goals have been met or unmet. Long term care plans were updated to reflect changes to care following evaluations.</p>

timely manner.		
<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 previous audit identified potential burn hazards in the environment. These have been managed and added to the hazard registers. The environment is well maintained and safe. There is appropriate equipment to provide hospital (medical) care.</p> <p>The building holds a current 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>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection control policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. Monthly registers of types of infection are developed and analysed with results provided to staff at the monthly integrated and staff meetings. Two outbreaks have occurred since the previous audit and have been reported and appropriately managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service endeavours to practice restraint minimisation and safe practice, as evidenced in the restraint policy and interviews with staff. There are 12 residents requiring restraint and no residents requiring enablers. There is a documented definition of restraint and enablers in the policies, which is congruent with the definition in NZS 8134.0.</p> <p>Staff have had training around restraint minimisation and the management of challenging behaviours.</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 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Moderate	Residents and family are aware of how to lodge a complaint as determined during interviews. All complaints are kept in a folder and the 12 complaints reviewed from 2015 all had a documented investigations. Five of the twelve complaints for 2015 had a documented acknowledgement and response to the complainant within the timeframes required by the Code of Rights.	<p>(i) Five of twelve complaints for 2015 did not have a documented acknowledgement within five days.</p> <p>(ii) Three of the 12 complaints for 2015 did not have documented follow up with the complainant (noting that two had documented follow up with the resident or EPOA but not the complainant).</p>	<p>(i) And (ii) Ensure that all complaints are acknowledged within five days and that all complainants are informed of the outcome of the complaint.</p> <p>60 days</p>
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is</p>	PA Low	All complaints and associated documentation are kept in an orderly complaints folder. There is no complaints register.	Complaints are not logged into a complaints register.	Ensure all complaints are logged in a complaints register.

maintained that includes all complaints, dates, and actions taken.				90 days
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	The service has a set of policies and procedures that have been regularly reviewed. The newly appointed hospital manager and general manager report that they intend to review the content of all policies. Policies around pressure area prevention and management (link 1.3.6.1) and interRAI requirements are in the process of being completed.	Policies have not been updated to reflect interRAI requirements.	<p>Ensure policies are updated to include interRAI requirements.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	The service completes internal audits and identifies areas for improvement. All shortfalls noted (from internal audits or other sources) had corrective action plans developed. However these were not consistently signed off as completed.	Eleven of the thirty five corrective action plans developed have not been signed off as implemented.	<p>Ensure corrective action plans are implemented and signed off.</p> <p>90 days</p>

<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>The prescribing of regular medications met legislative requirements. Ten of 12 charts evidenced that the GP had prescribed indications for the use of 'as required' medications. The standing order medications met prescribing requirements, however, annual reviews have not occurred. All stock medications and as required medication expiry dates are checked monthly as per the checklist (sighted). There were no dates on eye drops when they were opened. Clinical equipment including oxygen regulators and suction had been checked and calibrated with the exception of syringe drivers. Twelve medication charts were reviewed and a gap identified around photo identification and allergy status.</p>	<p>The following shortfalls were identified: 1) no indication for use on two medication charts for as required medications, 2) the standing orders had not been reviewed since November 2014, 3) five eye drops in use in the medication trolleys were not dated on opening, 4) the facility own three syringe drivers which were not calibrated at the time of the audit, 5) there was no allergy status known for one respite care resident, and 6) there was no photo identification on five out of 12 medication charts.</p>	<p>1) Ensure there are indication for use for all as required medications, 2) review the standing orders annually, 3) ensure all eye drops are dated on opening, 4) ensure syringe drivers have a functional check and calibration annually, 5) ensure the allergy status is known for respite care residents, and 6) ensure all medication charts have photo identification.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the</p>	<p>PA Moderate</p>	<p>There have been 38 admissions (31 at hospital level and seven at rest home level) since 1 July 2015 as determined by the residents register. All new admissions have had an initial assessment completed including relevant risk assessments. All residents have long term care plans in place to guide staff in timely and safe delivery of care. However, none have interRAI assessments completed as determined by the interRAI assessments due report including one of the six files reviewed.</p>	<p>One of six files sampled were for residents admitted since 1 July 2015. This resident (rest home) did not have an interRAI assessment completed within 21 days of admission. The sample was extended to include all residents admitted since 1 July 2015. Of the 38 residents admitted since 1 July 2015, none had had interRAI assessments completed within 21 days. Advised that the facility only have two registered nurses (originally the facility employed five interRAI trained registered nurses).</p>	<p>Ensure residents have an interRAI assessment completed within 21 days of admission.</p> <p>90 days</p>

consumer.				
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA High</p>	<p>There are comprehensive wound assessment forms available for use. Wound assessments, wound maps, wound documentation (dressing charts) and wound progress notes have been completed for five skin tears and one minor superficial wound. Dressing records and wound progress notes have been maintained for one chronic wound and two pressure injuries, however, wound assessments have not been completed. Wound assessments and wound care documentation is the responsibility of the registered nurse, however, there was no RN signature on the completed wound assessments.</p> <p>There are no documented policies and procedures to guide staff around pressure injury prevention and management. Pressure injury risk assessment tools have been completed for four hospital resident files sampled identified as high risk. There were no documented outcomes of risk assessment tools and pressure injury prevention and management. On the day of audit air alternating mattresses were seen in use for the two residents with pressure injuries.</p> <p>The discharge plan for a resident (interim care) identified the use of analgesia for pain management. An initial nursing assessment did not include a pain assessment. Progress notes recorded the effectiveness of as required pain relief.</p>	<p>1) Issues around pressure injury management are identified as follows:</p> <p>a) There are no policies or procedures documented to guide staff in identifying and managing pressure area risk or identified pressure injuries.</p> <p>b) Comprehensive wound assessments (including size of wound) have not been completed for two hospital residents with pressure injuries including one hospital resident with a facility acquired grade 2 pressure injury of the upper back and one hospital resident with a facility acquired grade 4 pressure injury of the heel. Wound care documentation does not reflect the current stage of the pressure injury. Wound assessments in place do not identify the RN completing the assessment. There is additionally one hospital resident with a chronic venous ulcer of leg identified September 2015 who also does not have a comprehensive wound assessment documented or sufficient documentation around ongoing wound evaluation.</p> <p>c) Four hospital residents (including one with a current grade 4 facility acquired pressure injury and one with a current grade 2 facility acquired pressure injury) have been assessed as high risk of pressure injury. The care plans do not reflect the level of risk and do not have appropriate pressure injury prevention and management documented in the care plans.</p> <p>d) There is no positioning/turning chart in place for the one resident with a grade 4 pressure injury.</p>	<p>1a) Develop policies and procedures to manage pressure injury risk and pressure injuries and ensure staff are familiar with these.</p> <p>b) Ensure comprehensive wound assessments are completed for all wounds. Ensure the RN signs the wound assessment on completion. Ensure wound assessments are reviewed as required to reflect the current status of the wound.</p> <p>c) Ensure care plans reflect the outcomes of the pressure injury risk assessment tool. Ensure pressure injury prevention and management including use of pressure injury equipment is documented in the care plans.</p> <p>d) Ensure that appropriate interventions to</p>

			<p>2) There was no pain assessment completed for a resident who identified pain and discharged on analgesia.</p>	<p>reduce the risk of pressure injury are implemented and documented</p> <p>2) Ensure pain assessments are completed on admission for residents who identify with pain.</p> <p>7 days</p>
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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.