

Presbyterian Support Services (South Canterbury) Incorporated - Margaret Wilson Complex

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:	Presbyterian Support Services (South Canterbury) Incorporated
Premises audited:	Margaret Wilson Complex
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 23 November 2016 End date: 23 November 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:	69



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

General overview of the audit

The Margaret Wilson complex is part of the Presbyterian Support South Canterbury (PSSC) organisation. Margaret Wilson is one of three aged care facilities managed by PSSC. The service is certified to provide rest home, hospital (medical and geriatric) and physical disability level care for up to 70 residents with 69 residents on the day of audit.

The nurse manager has been in the role for three years and is supported by a nurse team leader, registered nurses, PSSC management and care staff. Family and residents interviewed spoke positively about the care and support provided.

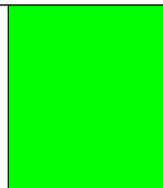
This surveillance audit was conducted against the Health and Disability Sector Standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

The service has addressed one of the two previous audit findings relating to monitoring of enablers. Further improvements continue to be required around care plan documentation.

This audit identified that improvements are also required around corrective actions, staff training, wound management and medication management.

Consumer rights

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

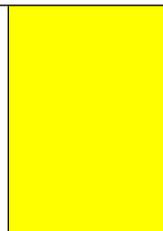


Standards applicable to this service fully attained.

Care plans accommodate the choices of residents and/or their family/whānau. Discussions with families identified that they are fully informed of changes in health status. Complaints and concerns have been managed and a complaints register is maintained.

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.

The PSSC board of directors provides governance to the service. The service is implementing the Eden Alternative philosophy. The quality and risk management programme includes service philosophy, goals and a quality planner. Quality improvement activities including benchmarking, are conducted. Meetings are held to discuss quality and risk management processes. Residents meetings have been held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Appropriate employment processes are adhered to. There is a roster that 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>
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Assessments, care plans and reviews are completed by a registered nurse within the required timeframes. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. General practitioners review residents at least three-monthly or more frequently if needed. Aspects of medication management require improvement. Meals are prepared off-site at another PSCC site in Timaru and delivered in insulated containers to the facility. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

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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The building has a current 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.
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Restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service has achieved a restraint-free environment. Seven residents have enablers, which are voluntary.

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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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	12	0	2	3	0	0
Criteria	0	34	0	2	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A complaints policy and procedures are in place. The chief executive officer (CEO) of PSSC manages all complaints for the service and allocates investigations to senior management depending on the nature of the complaint. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. A review of the complaints register evidences that the appropriate actions have been taken in the management and processing of complaints. A complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Eight residents interviewed (two hospital, four rest home and two younger persons with disabilities YPD), stated they were welcomed on entry and were given time and explanation about the services and procedures. A sample of incident reports reviewed and associated resident files, evidenced recording of family notification. Two relatives interviewed (one YPD and one hospital) confirm they are notified of any changes in their family member's health status. The nurse manager and registered nurses were able to identify the processes that are in place to support family being kept informed.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items</p>

<p>conducive to effective communication.</p>		<p>they have to pay for that are not covered by the agreement. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.</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>Margaret Wilson is part of the Presbyterian Support South Canterbury (PSSC) organisation. The nurse manager is a registered nurse and maintains an annual practising certificate. She has been in the role for three years. The nurse manager is supported by a registered nurse team leader, registered nurses, care staff and PSSC management team including the general manager for services for older peoples and the chief executive officer (CEO). The organisation has an overall strategic plan and quality programme with specific quality initiatives conducted at Margaret Wilson. The organisation has a philosophy of care which includes a mission statement. The Eden Alternative philosophy of care is an important part of the organisation which is understood and implemented by all members of the organisation including the Board. Buffet style of dining for rest home residents continues to be positively received by residents. The principles of addressing helplessness, boredom and loneliness are incorporated in the cares provided and in the activities programme. Staff are encouraged to share and record 'Eden moments' where their actions have made a difference to residents in some way. The service aims to maintain an environment which is as home-like as possible.</p> <p>The nurse manager has completed in excess of eight hour's professional development in the past twelve 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>	<p>PA Low</p>	<p>Presbyterian Support South Canterbury has an organisational strategic plan (2014-2019) and a business plan (2014-2016). The quality plan for PSSC also includes specific quality goals and risk management plans for PSSC Margaret Wilson. The current quality goals include implementation of the Eden Alternative and introduction of an electronic medication system. Interviews with staff confirmed that quality data is discussed at monthly staff meetings and is included in the monthly staff newsletter. A monthly combined quality improvement (CQI) meeting is held for all three PSSC facilities where all quality data and indicators are discussed. The CQI committee includes nurse managers from all facilities and clinical coordinators. Minutes of these meetings are made available to all staff. The quality and risk management programme is designed to monitor contractual and standards compliance. The service's policies are reviewed at organisational level by the clinical managers group with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. A monthly report is provided to the general manager for services for older people and monthly data is collated in relation to PSSC benchmarking data.</p> <p>Resident/relative meetings are held. Restraint and enabler use is reported within the registered nurses' meetings.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Corrective actions have not always been developed for shortfalls identified or signed off</p>

		<p>when completed.</p> <p>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. The health and safety meeting includes discussion around equipment, resources, hazards, staff incidents and training requirements. There are 10 staff on the health and safety committee and all have completed a minimum of stage 1 training. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention.</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>	FA	<p>There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the nurse manager and analysis of incident trends occurs. Incidents are included in the PSSC continuous quality improvement programme. There is a discussion of incidents/accidents at health and safety meetings including actions to minimise recurrence. Clinical follow up of residents is conducted by a registered nurse as evidenced in the 21 reports reviewed for November 2016. Discussions with the nurse manager and PSSC management team confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Family notification was recorded on incident forms and in progress notes reviewed.</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>Human resources management policies are in place which includes recruitment. 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. Seven staff files were reviewed and evidence that reference checks are completed before employment is offered. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice.</p> <p>In-service education programme for 2015 has been completed and a plan for 2016 is being implemented, however, not all training requirements have been provided. Caregivers are facilitated to complete an aged care education programme. Staff attend an annual compulsory study day which includes training around the Eden Alternative programme. The nurse manager and registered nurses are able to attend external training including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed. Six-monthly fire evacuation drills have been conducted.</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>	FA	<p>PSSC policy includes rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of all residents. At least one registered nurse and one caregiver is rostered on at any one time in the hospital unit, one caregiver in the physical disability unit and two care staff in the rest home. There is a registered nurse employed to oversee the care in the hospital and physical disability unit (team leader) and a registered nurse employed to oversee the rest home area. Advised that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</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>	PA Moderate	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. The facility uses an electronic medication management system. Not all medicines are appropriately stored in accordance with relevant guidelines and legislation. A registered nurse checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy. The medication rooms in three areas were clean and well organised. The medication fridges have temperatures recorded daily and these are within acceptable ranges. The medication round observed during the audit was completed correctly.</p> <p>Registered nurses, enrolled nurse and senior caregivers responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as second checker have also completed medication competencies. The standing orders have been approved by the GPs annually and meet the legislative requirements for standing orders.</p> <p>Photo identification and allergy status were documented on all twelve medication charts reviewed. All medication charts for permanent residents had been reviewed by the GP at least three-monthly. Not all resident medication administration signing sheets corresponded with the medication chart.</p> <p>There is a self-medicating resident's policy and procedure in place. There is currently one rest home resident who self-administers medications. Three-monthly competency assessments were completed. The resident's medication is stored in a locked drawer in their room.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>The facility has a large well-appointed kitchen. All meals are prepared off-site at another PSSC village in Timaru and delivered to the facility in insulated containers. There is a dining area in each unit. Food is transported to the dining areas in insulated boxes to be served from Bain maries in servery areas to the residents. Food temperatures are</p>

<p>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>recorded on delivery and again prior to serving.</p> <p>The facility provides a buffet service in the rest home for the breakfast and evening meal as part of the Eden philosophy to allow residents' food choices and maintain independence. Residents who wish to have breakfast in bed also have a buffet choice. Residents, relatives and staff report positively about the buffet service and residents were observed at meal times independently or with assistance enjoying the buffet. Meals are delivered to residents in their rooms when required. Kitchen staff are trained in safe food handling and food safety procedures were adhered to. Staff were observed assisting residents with their lunchtime meals and drinks. Special eating utensils are available. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the registered nurses or team leader. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Resident meetings, surveys and feedback forms allow for the opportunity for resident feedback on the meals and food services generally. Staff also complete food feedback forms. Residents and family members interviewed indicated satisfaction with the food service.</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>Six resident files were reviewed. Initial and long-term care plans were in place for all six residents. The service has a specific acute health needs care plan that included short-term cares. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Not all long-term care plans documented the resident's problem/need, objectives, interventions and evaluation for identified issues. Activity plans are developed for each resident as evidenced in all files sampled. This aspect of the previous finding has been addressed.</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 desired outcomes.</p>	<p>PA Moderate</p>	<p>Registered nurses (RNs), enrolled nurses and caregivers follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse or wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans were not fully completed for all wounds. On the day of audit there were eight wounds currently being treated which included: blisters, two skin tears, one surgical wound and one resident with four wounds. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses and caregivers demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as food and fluid charts, regular</p>

		monitoring of bowels and regular (monthly or more frequently if required) weight management. Turning charts were not evidenced to be completed (link to 1.3.5.2).
<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 activities programme follows the Eden philosophy and is resident focused. The programme meets the recreational needs of the residents and reflects normal patterns of life. The activities staff (two are diversional therapists) provide an activities programme over seven days each week. The programme is planned monthly and residents receive a personal copy of daily activities. Weekly activities are displayed on noticeboards around the facility. There are two programmes developed, one for rest home and one for the hospital. Residents can attend any activity provided on the programmes.</p> <p>Residents with physical disability attend activities in the rest home/hospital and the community that are appropriate to meet their needs. An activity profile is completed on admission in consultation with the resident/family (as appropriate). The activities documentation in the resident files sampled reflected the specific requirements of each resident. Activity plans were evidenced to have been reviewed six-monthly for all permanent residents. Residents interviewed reported that the activity programme had a focus on maintaining independence, reducing boredom and was varied and fun.</p> <p>The facility has a van that is used for resident outings.</p> <p>The facility had transformed a conservatory into a Santa's Grotto. Residents were able to have their photos taken with Santa and these photographs were used to print Christmas cards to send to their families. Families had also been invited to have their photograph with Santa. Residents interviewed reported that it felt very special to have their photograph taken with their children and grandchildren at Christmas.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly. There was at least a three-monthly review by the GP. All changes in health status were documented and followed up. Reassessments have been completed using interRAI LTCF for all residents who have had a significant change in health status. The RN completing the plan signs care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing (link finding 1.3.5.2), as sighted in resident files sampled.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	FA	<p>The service displays a current building warrant of fitness which expires on 1 June 2017.</p>

appropriate, accessible physical environment and facilities that are fit for their purpose.		
<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 is an integral part of the infection control programme and is described in PSSC's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short-term care plans are used. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to PSSC general manager of services for older people. Infections are part of the benchmarking targets. Outcomes and actions are discussed at health and safety meetings, CQI meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the nurse manager. There have been no outbreaks 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>The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraint. Enablers are voluntary. Seven residents have enablers which includes six hospital residents with bedrails. One resident in the physical disability unit also has enablers in the form of bedrails, a lap belt and a communication board which attaches across a custom-made chair. Documentation has been completed in relation to consent, assessment, monitoring and care planning for the enablers. Monitoring of enablers and three-monthly reviews has been completed. The service has addressed this previous audit finding. Staff interviews and staff records evidence guidance has been given on restraint minimisation, enabler usage and prevention and/or de-escalation techniques including non-violence crisis intervention. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Restraint use audit has been conducted and restraint has been discussed as part of CQI meetings. The general manager for services for older people is the designated restraint coordinator.</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 1.2.3.8</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	A range of internal audits are completed to review the care and services provided. Corrective actions are documented where any shortfalls are identified and have been completed and signed off for the privacy audit, housekeeping and medication storage audits. Corrective actions for medication management, laundry, hand hygiene and the monthly resident file audit have not been completed or signed off.	Corrective actions (where documented) are not consistently completed or signed off when completed.	<p>Ensure that all corrective actions are completed and signed off.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service</p>	PA Low	Staff are encouraged to complete ‘walking in another’s shoes’ dementia course. The education programme includes compulsory and non-compulsory training. Not all required training has been provided in the past two years. Registered nurses complete syringe driver training. Care staff working	Education sessions around the Code of Consumer Rights, cultural safety and pressure injury prevention training for care staff has not been provided in the past	Provide evidence that all training needs are provided.

providers to provide safe and effective services to consumers.		with YPD residents have been provided with training around non-violence crisis intervention management.	two years.	180 days
<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</p> <p>Moderate</p>	<p>Ten of twelve medication charts reviewed were completed correctly. Eleven of twelve electronic medication signing sheets reviewed evidenced that medication had been given as prescribed. Three-monthly reviews of medications are completed by the GP. Not all review changes had been documented. Medication rooms are located in each area. Controlled medication prescribed for one rest home resident who self-administers was not evidenced to be stored as per the Ministry of Health Medicines Care Guides for Residential Aged Care 2011. Gaps were evidenced in the controlled drug register. Two staff signatures were not evidenced on two recent occasions when controlled medication was being signed out for administration.</p>	<p>i) Continuous oxygen therapy was not prescribed on the medication chart for one rest home resident who was observed receiving continuous oxygen therapy during the audit;</p> <p>ii) One hospital resident is prescribed continuous oxygen as a regular medication which was not evidenced to have been administered since May 2016. The medication chart had been reviewed by the GP but had not been updated to reflect that the resident no longer required the administration of continuous oxygen therapy;</p> <p>iii) One rest home resident who self-administers medication was evidenced to have Morphine Elixir (controlled medication) stored in a locked drawer in her room. The resident self-administered Morphine Elixir as required. This was corrected on the day of audit; and</p> <p>iv) A review of the controlled drug register evidenced two signatures were not consistently documented for the signing out of controlled medication to be administered.</p>	<p>i) Ensure that medication is prescribed prior to administration;</p> <p>ii) Ensure that medication is administered as prescribed or reviewed by GP if no longer required;</p> <p>iii) Ensure controlled medications are stored in accordance with legislative guidelines;</p> <p>iv) Ensure that two staff signatures are recorded in the controlled drug register when medication is being signed out for administration.</p>

				30 days
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>A three-monthly assessment to self-administer medication had been completed for one resident who self-administers medication. The staff verbally check with the resident on each shift that medication has been taken as prescribed. The electronic medication chart did not document, or alert staff, that the resident self-administers all medications.</p>	<p>The electronic medication chart reviewed did not document that the resident self-administers medications.</p>	<p>Ensure that the electronic medication charts document that the resident self-administers medications.</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>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>Four of six residents care plans included all interventions to support identified needs of residents and direct care and support of staff including activity interventions. In two hospital files sampled, the care plans did not reflect the resident's current needs.</p>	<p>i) One hospital resident's care plan did not reflect the current pressure injury prevention interventions that were being implemented. These included the use of a pressure relieving chair and four-hourly position changes. Changes of position were not evidenced to be documented by either the use of a turning chart, or recorded in progress notes;</p> <p>ii) One hospital resident is prescribed prophylactic antibiotics to prevent recurrent urinary tract infections. This was not documented in the care plan. The resident has type II diabetes. The care plan documented that BSL recordings were to be managed within the target range, however, no target range to guide staff was</p>	<p>(i-ii) Ensure care plans reflect the management of all care requirements and that appropriate interventions to meet resident needs are recorded.</p> <p>60 days</p>

			documented in the care plan. The management of hypo/hyperglycaemia was not documented in the care plan.	
<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</p> <p>Moderate</p>	<p>Wound assessment and treatment plans were fully completed for four of eight wounds reviewed.</p>	<p>i) Four of eight wound assessments were not fully completed to include the size of wound or frequency of review;</p> <p>ii) One resident had four wounds documented on one wound assessment. The treatment plan did not identify the treatment required for each separate wound.</p>	<p>(i-ii) Ensure that wound assessments are fully completed and that a treatment plan is completed for each wound.</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.