# Oceania Care Company Limited - Melrose Park

## 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Melrose Rest Home and Retirement Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 6 December 2016 End date: 7 December 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:** 74

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Melrose Rest Home and Retirement Village provides rest home and hospital level care for up to 88 residents. There were 74 residents at the facility on the days of audit.

This surveillance audit was conducted against the relevant aspects of the Health and Disability Service Standards and the service’s contract with the district health board. The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, management, staff and a general practitioner.

The two areas identified as requiring improvement at the last certification audit, relating to residents’ privacy and initial medical assessments, have been met.

There are six areas identified as requiring improvement relating to: corrective actions; medication management; residents’ recordings; wound management and residents’ activities.

## Consumer rights

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

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service is accessible. This information is brought to the attention of residents and their families on admission to the facility. Residents confirmed their rights are being met, staff are respectful of their needs and communication is appropriate.

The business and care manager is responsible for the management of complaints and a complaints register is maintained.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Oceania Care Company Limited is the governing body and is responsible for the services provided at this facility. A business plan and quality and risk management systems document the scope, direction, goals, values and mission statement. The quality and risk management system supports the provision of clinical care at the service. Systems are in place for monitoring the services provided. The quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status and clinical indicator reports.

The service is managed by a business and care manager who is supported in their role by a clinical manager. The clinical manager is responsible for the oversight of the clinical services in the facility.

There are human resource policies implemented around recruitment, selection, orientation, staff training and development. An in-service education programme is provided for staff on a regular basis and a staff training register is maintained. New staff are required to complete an orientation programme.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. Staff are allocated to support residents as per their individual needs.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents’ needs are assessed on admission by a registered nurse. Residents’ needs, goals and outcomes are recorded in residents’ care plans. The care plan evaluations are conducted on a regular basis or when a resident’s condition changes. Residents interviewed report being informed, involved and satisfied with services provided.

The activities programmes provide a wide range of activities and involvement with the wider community.

Medicine management policies and procedures are in place to guide practice.

The menu has been reviewed by a registered dietitian and meets nutritional requirements and guidelines. Residents’ special dietary requirements, need for assistance with meals or need for modified equipment are met. Residents interviewed confirmed satisfaction with meals.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

A current building warrant of fitness is in place. There have been no building modifications since the last audit.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident requests an enabler to assist them to maintain independence and/or safety. Enabler requests and use are voluntary. Staff education in restraint, de-escalation and challenging behaviour is provided.

## Infection prevention and control

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

Surveillance of infections is occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections is collated, analysed and entered in the clinical indicators on the Oceania intranet. The results of surveillance are reported through all levels of the organisation, including governance.

This information is reviewed by the Oceania clinical quality team and reported to the Oceania board on a monthly basis.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 13 | 0 | 2 | 3 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 2 | 4 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policies and procedures are compliant with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).  Residents and family are advised of the complaints process on admission. There are appropriate systems in place to manage the complaints process and the complaints forms are accessible at the facility. Residents demonstrated an understanding and awareness of how to make a complaint.  The business and care manager is responsible for the management of complaints. A complaints register is maintained and a sample of complaints for 2016 were reviewed and evidenced the complaints process is followed and complaints are managed appropriately.  The business and care manager stated there had been one complaint to the Ministry of Health and one to the Health and Disability Commissioner (HDC) since the last certification audit. The Ministry of Health complaint was referred to the DHB and was investigated by DHB staff. Interview with the DHB staff member confirmed corrective action plans have been developed and are in process of implementation. The HDC complaint has been investigated and is now closed. No other external agencies have had complaints submitted, as stated by the business and care manager. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | There are single, two bedded and four bedded rooms at the facility. The shared rooms have curtains provided for residents’ privacy. The criterion 1.1.3.1 was identified as requiring improvement at the last certification audit relating to curtains in two residents’ bedrooms not maintaining residents’ privacy. This has been addressed by the organisation and the criterion is met.  Staff were observed knocking on closed doors before entering residents’ rooms and maintaining the privacy and dignity of residents during personal cares.  Residents confirmed they are treated respectfully and that their individual needs and preferences are acknowledged and accommodated. The resident and family satisfaction surveys for 2016 indicated high resident satisfaction concerning their rights being respected. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Review of residents’ clinical files evidenced timely and open communication with residents and family members. Communication with family members is recorded in the progress notes and on the family communication sheets.  Staff and management interviewed confirmed family members are kept informed about any change in a resident’s condition and if any adverse event occurs and this was evidenced in clinical files reviewed.  The business and care manager advised that interpreter services are able to be accessed from the district health board (DHB), if required. There were no residents at the facility requiring interpreter services on audit days.  Relevant information is provided to residents and their families as part of the information admission pack. Family meetings inform family members of facility activities and provide opportunity for family members to discuss issues/concerns with management. Minutes of family meetings were sighted. The last family meeting was held in October 2016 and discussion relating to the satisfaction survey results was included. Family members were not able to be interviewed on audit days due to their time constraints or their unavailability. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Melrose Rest Home and Retirement Village is part of the Oceania Care Company Limited with the executive management team providing support to the service.  Communication between the service and the managers takes place on at least a monthly basis. The clinical and quality manager and the operations manager provided support during the audit. The monthly business status report provides the executive management team with progress against identified indicators.  The service has a documented mission statement, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training.  The facility can provide care for up to 88 residents with 74 beds occupied at the audit. This included 35 residents requiring rest home level care and 39 residents requiring hospital level care. Three residents were identified as being under the young people with disability contract, one at rest home level and two at hospital level.  The business and care manager (BCM) is responsible for the overall management of the service and has been in their role for three years. The BCM has previous management experience in residential care and has completed health care management education. The BCM attends core study days and additional training and education specific to management exceeding eight hours annually.  The clinical care service is overseen by the clinical manager (CM) who is a registered nurse (RN) and has been in this position for approximately a year. The CM has past experience in clinical management at another aged care facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The service uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff and staff are informed of new and revised policies.  The Oceania Care Company Limited has processes in place for facilities to maintain the quality and risk management system and monitor the key components of service delivery. There is documentation that includes collection, collation, and identification of trends and analysis of data. Internal audit schedule is implemented and results are communicated to staff. The 2016 family and resident satisfaction survey shows satisfaction with services provided and this was confirmed by residents interviewed. The satisfaction survey results record previous survey results and comparisons of data. There was evidence of improvements in results of satisfaction surveys.  Facility meetings provide a forum of communication with all staff, residents and families. Staff report that they are kept informed of quality improvements. Residents confirmed residents’ meetings provide an opportunity for discussions with staff and management. The meeting minutes evidenced when areas requiring improvement have been identified these are not consistently allocated to a person responsible for the corrective actions to be implemented, timeframes are not always recorded and the corrective action sign off is inconsistently recorded.  The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed and risks minimised or isolated. Health and safety is audited monthly with a facility health check completed by the clinical and quality manager. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the clinical manager and signed off by the business and care manager when completed. Corrective action plans to address areas requiring improvement are documented in accident/incident forms. The registered nurses undertake assessments of residents following an accident and this is recorded on the accident/incident form and in the resident’s clinical file (refer to 1.3.3.3).  Staff confirmed they are made aware of their responsibilities for completion of adverse events through job descriptions, policies and procedures, and staff training.  The business and care manager is aware of the requirements of essential notifications to relevant authorities. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Written policies and procedures in relation to human resource management are documented and implemented. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.  The in-service education programme and the core study days were reviewed and evidence staff education is provided to all staff. The core study days are provided for RNs, health care assistants and non-clinical staff. The core study days provide mandatory education and training in the required areas relevant to the levels of staff responsibilities and authority. Individual staff attendance records and attendance records for each education session were reviewed and evidenced ongoing education is provided. Competency assessment questionnaires are current for medication management and restraint. The clinical manager and six of the twelve RNs have the required interRAI assessments training and competencies.  The required New Zealand Qualifications Authority approved aged care education is part of the core study days. Staff are supported to complete education via external education providers.  An appraisal schedule is in place and current staff appraisals were in the staff files and on the staff appraisal register.  An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. Orientation for staff covers the essential components of the service provided. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy. Registered nurse cover is provided seven days a week. On-call arrangements are known to staff.  Residents reported staff provide them with adequate care. Care staff reported there are adequate staff available and that they are able to get through their work. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medication areas in the hospital and rest home wings, including controlled drug storage, evidence an appropriate and secure medicine dispensing system. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stock takes. The medication fridge temperatures are conducted and recorded. Expired medicines are returned to pharmacy and expiry dates checked were all within dates for safe use.  All staff authorised to administer medicines have current competencies. The medication rounds were observed and evidenced that resident photos on medicines charts were not dated and did not resemble other photos in their system. One resident’s medicines file did not have photo identification and one of the charts did not have specific allergies recorded (as identified in the residents file). The medication files were typed up by the pharmacy, however, the general practitioner had not signed the chart. During the medicines round sign-off on administering medicines occurred prior to administration.  There were three residents self-administering medicines (ointments, puffers and eye drops). However, there was no consistent evidence that these residents are monitored as being competent to self-administer medicines.  Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted. Abbreviations used by staff are approved, known by staff and appropriate. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Personal food preferences of the residents, special diets and modified nutritional requirements are known and accommodated in the daily meal plan. The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s documented assessment of the planned menu. Special equipment, to meet resident’s nutritional needs, was sighted.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.  The effectiveness of chemical use, cleaning, and food safety practices in the kitchen are monitored. A cleaning schedule was sighted as is verification of compliance. Food temperatures are recorded as are fridge, chiller and freezer temperatures. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Review of resident files confirmed they were assessed by a medical practitioner within 48 hours after admission to the service. All three monthly medical assessments are completed within the required timeframes. The previous requirement for improvement relating to medical assessment to be completed within 48 hours of admission has been implemented. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | The residents' care plans evidence detailed interventions based on assessed needs, desired outcomes or goals of the residents, however, this was not consistent with residents’ needs and desired outcomes in relation to wound care.  The general practitioner documentation and records are current. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated. Residents expressed satisfaction with the care provided.  There were sufficient supplies of equipment available that comply with best practice guidelines and meet the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | In interviews, the diversional therapists (DTs) confirmed the activities programmes meet the needs of the service group and the service has appropriate equipment. There is an activities programme for the rest home, one for the hospital residents and residents under 65 have individual care plans on file which identify their individual needs and goals. The facility had three residents under 65.  Regular exercises and outings are provided for those residents able to partake. The activities programmes include input from external agencies and support ordinary unplanned/spontaneous activities, including festive occasions and celebrations. There are current, individualised activities care plans in the residents’ files. The residents’ activities attendance records are maintained.  One-on-one activities are conducted and although the service provider records the occurrences of one-on-one activities; they do not record the duration or the content of these activities. This is a requirement for improvement. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Timeframes in relation to care planning evaluations are documented. The residents' care plans are up to date and reviewed six monthly. There is evidence of resident, family, health care assistants, activities staff and GP input in care plan evaluations. In interviews, residents confirmed their participation in care plan evaluations and multidisciplinary reviews. InterRAI assessments for all resident files reviewed were up to date.  The residents’ progress records are entered on each shift. When a resident’s progress is different than expected, the RN contacts the GP as required. Short-term care plans are in some of the residents’ files and used when required. The family are notified of any changes in resident's condition, confirmed at resident and staff interviews.  There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is displayed at the facility. The business and care manager stated there have not been any alterations to the building since last audit. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection control surveillance policy identifies the requirements around the surveillance of infections. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Residents’ files evidenced the residents who were diagnosed with an infection had a short-term care plan.  Monthly surveillance analysis is completed, reported to staff and entered in the clinical indicators on the Oceania intranet. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board on a monthly basis.  In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents’ files.  In interview, the business and care manager confirmed there had been an outbreak at the facility since the last audit and this was reported to authorities as required and contained within the area identified. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented. There was one resident at the facility using an enabler and six residents using restraint on the days of the audit. The restraint and enabler use is documented in residents’ care plans.  The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. |

# Specific results for criterion where corrective actions are required

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

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

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

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.8  A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | The internal audits evidence when corrective actions are identified, these have a corrective action plan, a person responsible for the plan is identified, timeframes are recorded and the corrective action is implemented, this is signed off as completed.  The meeting minutes do not consistently evidence when areas requiring improvement have been identified, notation of a responsible person, timeframes for the corrective action recorded and the corrective action signed off when completed. There were a number of corrective actions that have been ongoing from meeting to meeting. | Meeting minutes do not consistently evidence corrective actions are allocated to a staff member, given timeframes for completion and sign off when a corrective action has been implemented. | Provide evidence corrective actions are addressed by developing and implementing a corrective action plan and recording this information.  180 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medicines management systems are in place and policy is accessible for guiding practice. During the medicines round there were several areas for improvement identified. Not all medicines charts had photo identification, photos of residents were not being dated and some of the photos are not sufficiently current enough to safely identify the resident by using the photo. One medicines chart did not reflect the allergies as identified in the residents’ file. The medicines charts were typed up by the pharmacy, however, the GP did not sign all charts. During the physical medicines round the RN signed medicines off prior to administration of the medicines. The checks of the medicines administration areas confirmed safe and appropriate practices. | i) Photos of residents were not dated.  ii) Some of the photos were not current enough to safely identify the resident by using the photo.  iii) Not all medicines charts had photo identification.  iv) One medicines chart did not reflect the resident’s allergies.  v) Medicines charts are typed up by the pharmacy, however, the GP did not sign all charts.  vi) Sign-off of medicines occurred prior to administration of the medicines. | Provide evidence the medication management system complies with legislation and guidelines.  60 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | There were three residents self-administering medicines (ointments, puffers and eye drops). However, there was no consistent evidence that these residents are monitored as being competent to self-administer medicines, this is a requirement for improvement. | Residents who self-administer medicines had not completed competency assessments to do so. | Provide evidence residents who self-administer medicines are competent to do so.  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | Residents’ care includes assessment, planning, provision, evaluation, review, and exit from care, however, when residents have unobserved falls, the service providers do not consistently complete neurological observations to ensure the safety of the resident within the required timeframes. | Unobserved falls, are not consistently monitored by timely neurological observations and assessments. | Staff to complete neurological observations for all unobserved falls, in a timely manner.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Review of the records and documentation for all 23 wounds recorded in their wound care folders showed that every wound was attended to. However, wound management did not consistently include a management plan, assessment records and regular photographic evidence and review. There was evidence of wounds having specialist in-put and GP notes included reference to wounds being monitored. Progress notes and handover records included evidence of wound care for the files reviewed through tracer methodology. | Wound care records are not consistently and comprehensively completed for all residents with wounds. | All wounds to be comprehensively managed.  60 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The activities programmes evidence a wide variety of activities for residents in the rest home and the hospital as well as residents who are under the age of 65. | The one-on-one activities do not evidence the duration or type of activities. | One-on-one activity records to include the duration and the type of activities for residents.  180 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

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| No data to display |

End of the report.