# Presbyterian Support Services (South Canterbury) Incorporated - Wallingford Rest home

## 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](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:** Presbyterian Support Services (South Canterbury) Incorporated

**Premises audited:** Wallingford Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 January 2017 End date: 24 January 2017

**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:** 30

# 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 |
|  | 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 Wallingford Rest Home is part of the Presbyterian Support South Canterbury (PSSC) organisation. Wallingford is one of three aged care facilities managed by PSSC. The service is certified to provide rest home level care for up to 32 residents with 30 residents on the day of audit.

The nurse manager has been in the role for six years and is supported by two 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 five of the six previous audit findings relating to advance directives, incident clinical follow-up, timeframes, assessments and medication prescription documentation. Further improvements continue to be required around care plan documentation.

This audit identified that improvements are also required around medical instructions/review of a resident and aspects of medication management.

The service has continued to exceed the required standard around implementation of the Eden Alternative principles.

## 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. |

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. Residents and families were well informed about how to complain. There have been no complaints.

## 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. |  | Standards applicable to this service fully attained. |

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

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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. |

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. Medication is appropriately prescribed and is administered by staff who have been assessed as competent. Meals are prepared on-site. 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

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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. |

The building has a current warrant of fitness.

## 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 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 and no residents use enablers.

## 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. |

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.

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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 | 16 | 0 | 0 | 3 | 0 | 0 |
| **Criteria** | 1 | 36 | 0 | 2 | 3 | 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 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has a clear policy around processes to obtain consent from the (competent) resident around resuscitation and advance care planning directives. A directive had been completed by the competent resident or the doctor (for residents who were not competent) in all files sampled. This is an improvement since the previous audit. There was evidence of discussion between the doctor and the resident and/or family around resuscitation wishes. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedure is in place. 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. Staff interviewed (one registered nurse, a diversional therapist and three caregivers) described processes they would follow if a resident or family wished to make a complaint. A review of the complaints register and interview with the nurse manager confirmed that there have been no complaints since the previous audit. Residents and families interviewed were familiar with how to make a complaint but reported there had been no need to do so. A complaints procedure is provided to residents within the information pack at entry. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Five residents interviewed 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 confirmed they are notified of any changes in their family member’s health status. The nurse manager and registered nurse interviewed were able to identify the processes that are in place to support family being kept informed. 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 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. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Wallingford is part of the Presbyterian Support South Canterbury (PSSC) organisation and provides care for up to 32 rest home level residents. Two beds are permanently allocated for respite residents. All 30 long-term beds were occupied by residents funded under the Aged Residential Care contract and the two respite beds were not occupied at the time of the audit.  The nurse manager is a registered nurse and maintains an annual practising certificate. She has been in the role for six years. The nurse manager is supported by two 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 Wallingford. 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 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. The required standard continues to be exceeded in this area.  The nurse manager has completed in excess of eight hour’s professional development in the past twelve months. |
| 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. | FA | 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 Wallingford. 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.  Resident/relative meetings are held.  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 been developed for shortfalls identified or signed off when completed.  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. Staff on the health and safety committee have all completed a minimum of stage 1 training. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. |
| 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 | 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 10 reports reviewed for December 2016. This is an improvement since the previous audit. Discussions with the nurse manager and PSSC management team confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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 | 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. Five staff files were reviewed (two registered nurses, one shift supervisor, one caregiver and the diversional therapist) and evidenced 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.  In-service education programme for 2016 has been completed and a plan for 2017 is being implemented and 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 were able to attend external training including sessions provided by the local DHB. Annual staff appraisals were evident in all staff files reviewed. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | PSSC policy includes rationale for staff rostering and skill mix. Sufficient staff are rostered on to manage the care requirements of all residents. There are two registered nurses and between them, routine cover is provided four to five hours per day, six days per week. In addition the nurse manager works 40 hours per week. A registered nurse is on call at all times. Staff reported that in addition to the registered nurse on call they are able to call registered nurses at another PSSC facility that has 24/7 RN cover if this is appropriate. 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. |
| 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 | 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 room was clean and well organised. The medication fridge had temperatures recorded daily and these are within acceptable ranges. The medication round observed during the audit was completed correctly.  Registered nurses and senior caregivers responsible for the administering of medications have not all completed annual medication competencies abut have completed annual medication education. Caregivers who act as second checker have also not all completed medication competencies.  Photo identification and allergy status were documented on all ten electronic medication charts reviewed. All medication charts for permanent residents had been reviewed by the GP at least three-monthly and indications for use was documented for all as required medications prescribed. This is an improvement since the previous audit. Not all resident medication administration signing sheets corresponded with the medication chart and the efficacy of as required medications was not always documented.  There is a self-medicating resident’s policy and procedure in place. There are currently four residents who self-administer medications. Three-monthly competency assessments were completed for two of these residents. The resident’s medication is stored in a locked drawer in their room. |
| 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 | The facility has a large well-appointed kitchen. All meals are prepared on-site by staff trained in food safety.  The facility provides a buffet service for all meals as part of the Eden philosophy to allow residents’ food choices and maintain independence. 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. 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. Residents and family members interviewed indicated satisfaction with the food service. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | In resident files reviewed all residents had InterRAI assessments that had been reviewed at least six monthly and as required. Behaviour assessments were completed when required (link 1.3.6.1) and ongoing pain monitoring and review of falls risk following falls were documented. These are improvements since the previous audit. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Five resident files were reviewed. Initial and long-term care plans were in place for all five 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. This previous shortfall continues to require improvement. Activity plans are developed for each resident as evidenced in all files sampled. This aspect of the previous finding has been addressed. |
| 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 | Registered nurses (RNs) and caregivers follow the care plan (link 1.3.5.2) 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 (eg, 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 (eg, 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.  Wound assessment, monitoring and wound management plans are available. There were no wounds at the time of the audit. The RNs have access to specialist nursing wound care management advice through the district nursing service.  Interviews with a registered nurse and caregivers demonstrated an understanding of the individualised needs of residents with the exception of one resident. There was evidence of pressure injury prevention interventions such as food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. Turning charts were evidenced to be completed (link to 1.3.5.2). |
| 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. | FA | 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 (one is a diversional therapist) provide an activities programme over six 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.  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.  The facility has a van that is used for resident outings and there is a wide range of engagement and interaction with the local community.  Residents reported that flexibility was strength of the day-to-day life at Wallingford, including the activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | 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. 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. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness. |
| 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 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 is entered onto 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. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents with restraint or enablers. 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. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  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 | Six of ten electronic medication signing sheets reviewed evidenced that medication had been given as prescribed. Three-monthly reviews of medications are completed by the GP. Staff document the time and dose of ‘as required’ medication administered but the effect is not always documented. All medication is stored in a clean treatment room and there was no expired medication. Not all current eye drops had been dated when opened. | (i) Four of ten electronic medication records have evidence of medications prescribed not administered with no documented reason for this. (ii) Three resident medication records reviewed did not have consistent evidence of the efficacy of PRN medication being recorded either in the electronic medication record or in the progress notes. (iii) One bottle of open eye drops had not been dated when opened. | (i) Ensure medications are administered as prescribed. (ii) Ensure the efficacy of ‘as required’ medication is documented. (iii) Ensure all eye drops are dated when they are opened.  60 days |
| Criterion 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | The service has a system for assessing competency to administer medications annually. At the time of the audit the manager was aware that competency assessments were overdue and planned to address the issue. | Four of five staff files reviewed (all of who administer medications) did not have a current medication competency assessment. | Ensure all staff who administer medications have annual assessments of competency to do so completed.  60 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | A three-monthly assessment to self-administer medication had been completed for two of four residents who self-administer medication. The staff verbally check with the resident on each shift that medication has been taken as prescribed and document this in the electronic medication chart. | Two of four residents who self-administer medications had not had a competency assessment reviewed as required by policy. | Ensure that regular assessments of competency are completed for any resident that self-administers medications.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Two of five residents care plans sampled included all interventions to support identified needs of residents and direct care and support of staff including activity interventions. | Three of five resident files sampled did not have interventions for all identified needs documented in the care plan. | Ensure all identified needs have related and required interventions documented in the care plan.  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 | The registered nurse interviewed demonstrated appropriate resident assessment skills and the GP interviewed confirmed this. Residents continue with their own GP. GPs visit routinely three monthly to complete three monthly reviews for the residents they provide care for and on, an as required basis. Four of five files sampled demonstrated that this practice had occurred and identified needs had been followed up by GPs and interventions completed as instructed by the GP. This had not occurred for one resident. | One resident with complex medical needs has been seen by the GP on a reactive basis but not had a comprehensive review of all medical issues documented by the doctor. This has resulted for confusion by staff around required needs and conflicting advice. This includes a documented required fluid restriction due to hypernatremia identified in hospital with no documented follow-up bloods taken and no documented review of this. Other sections of the file document the needs to increase fluids due to frequent UTIs. | Ensure that all residents have regular reviews by the GP in-line with contractual requirements and that required needs are clearly documented for staff to follow.  90 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.1.1  The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed. | CI | Wallingford rest home has adopted and implemented the Eden Alternative approach to their service which includes a philosophy of person centred care. All staff are trained in the Eden approach and this includes board members, management, care staff, kitchen, maintenance, laundry and cleaning staff. The organisation has received recognition from the Eden Alternative International Board in the USA, being awarded the International Seedling Award for outstanding progress in implementing this person-centred philosophy of care, in each of the three residential homes. Current Eden initiatives being implemented relate to reducing loneliness, helplessness and boredom. Staff interviewed at Wallingford were conversant with the Eden Alternative and were able to describe how the philosophy of care is implemented in everyday life. Training is provided for all staff on an annual basis. New staff are introduced to the philosophy at the compulsory orientation study day. | Wallingford has continued to embrace the Eden Alternative philosophy as evidenced in a tour of the facility, interviews with residents and family members and with discussions with staff. The service continues to use the buffet style of dining which continues to be positively received by residents. Residents interviewed advised that they enjoy the dining experience. The Eden approach has been adopted by staff with annual training provided. The principles of addressing loneliness, helplessness and boredom are incorporated in the cares provided, and in the activities programme. Residents are encouraged and empowered to remain integrated in the community. Wallingford initiatives include kindergarten visits, knitting for others less fortunate, baking, outings and visits to places of interest. The Eden alternative is a regular agenda item at resident meetings, staff meetings and organisational quality meetings. 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 and improvements to the environment and activities programme are made at least monthly to achieve this. In the 2016 survey the number of residents reporting loneliness had dropped from 66.6% in 2015 to 16%, feeling helpless, from 33.3% in 2015 to 28% and being bored from 40% in 2015 to 6%. |

End of the report.