

Mossbrae Healthcare Limited - Mossbrae Healthcare

Introduction

This report records the results of a Certification 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:	Mossbrae Healthcare Limited
Premises audited:	Mossbrae Healthcare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 23 March 2017 End date: 24 March 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:	59

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

Mossbrae Healthcare is certified to provide hospital (geriatric and medical) and rest home level care for up to 64 residents. On the day of audit there were 59 residents.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The facility is managed by an experienced registered nurse who has been in the role for two years. She is supported by a clinical manager (registered nurse). The facility manager reports weekly to the facility owners, who visit the facility at least monthly.

This audit has identified areas for improvement around the completion of corrective action plans, care planning, wound management, aspects of medication management and restraint documentation.

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.
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Mossbrae Healthcare seeks to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights and complaints management. Information on informed consent is discussed and provided to potential residents or their representatives prior to and on admission. The admission agreement is discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. 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.
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Mossbrae Healthcare has a business plan and quality and risk management programme that outlines objectives for the next year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme including hazard management.

Aspects of quality information are reported to monthly staff meetings, registered nurse/clinical meetings and at health and safety/infection control meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at regular resident meetings and via satisfaction surveys. There is a reporting process in place to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Mossbrae Healthcare has comprehensive job descriptions for all positions. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing levels and residents and family members report staffing levels are sufficient to meet resident needs.

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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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. Registered nurses are responsible for care plan development with input from residents and family. Family interviewed confirm that the care plans are consistent with meeting residents' needs and they are happy with the care provided. There is a three-monthly general practitioner review. Planned activities are appropriate to the residents assessed needs and abilities and families interviewed advised satisfaction with the activities programme.

There are policies and processes that describe medication management. Indications for use of 'as required' medications are documented.

An external catering company is contracted to provide the food service. All meals are prepared off site and delivered to the kitchen for serving. Residents' food preferences and dietary requirements are identified at admission. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and modified dietary needs are being met. There is dietitian review of the menu.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Appropriate training, information and equipment for responding to emergencies are provided. There is an approved evacuation scheme and emergency supplies for at least three days. A first aider is on duty at all times. The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

All but two bedrooms are single occupancy. There are two double rooms which had single occupancy at the time of audit. There are adequate numbers of toilets and showers. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are a number of small lounge areas throughout the facility in addition to its main communal lounge dining areas. The internal areas are ventilated and heated. The outdoor areas are safe and easily accessible.

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.		Some standards applicable to this service partially attained and of low risk.
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There is a restraint policy that includes restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently seventeen residents who require the use of a restraint and ten residents who have requested the use of an enabler. Staff are trained in restraint minimisation and challenging behaviour management.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented. It meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and as part of the ongoing in-service education programme. 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	43	1	3	3	0	0
Criteria	0	94	1	3	3	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (five caregivers, one registered nurse, one enrolled nurse, one diversional therapist, one facility manager and one clinical manager) confirms their familiarity with the Code. Interviews with residents (four rest home and six hospital) and six relatives (two rest home and four from the hospital) confirms that the services provided are in line with the Code. The Code is discussed at resident and staff and various facility meetings.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent and advanced directives were recorded as evidenced in the eight resident files reviewed (two rest home and six hospital). Staff advise that family involvement occurs with the consent of the resident. Discussions with staff confirms that they are familiar with the requirements to obtain informed consent for personal care, for example, entering rooms. Enduring power of attorney evidence is sought prior to admission, and activation documentation is obtained. Residents interviewed confirm that consent is obtained prior to staff undertaking any care or treatment. Residents also confirm that</p>

		information is provided to enable informed choices and that they can decline or withdraw their consent. Resident admission agreements are signed in all files sampled.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>There is a policy that describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyers. This includes advocacy contact details. The information pack provided to residents provides residents and family/whānau with advocacy information. The complaints process also includes informing the complainant of their right to contact the Health and Disability Advocacy Service. An advocate support person attends at least two resident meetings per year, and is available on request. Interview with staff, residents and relatives' evidences that they are aware of advocacy and how to access an advocate.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are encouraged to be involved in community activities and maintain networks with family and friends. Care staff report that residents are encouraged to build and maintain relationships. The residents and families confirmed this and that visiting can occur at any time. All residents are encouraged to maintain their independence and links to the community with examples provided.</p>
<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>The service has a complaints policy and complaints process. There are complaint forms available. Information about complaints is provided on admission. Interview with residents and relatives demonstrates an understanding of the complaints process. All staff can describe the process around reporting complaints.</p> <p>There is a complaint register. There were three complaints received from 2016 to date. No trends were identified. Verbal and written complaints are documented. All complaints have documented: investigation, time lines, corrective actions when required and resolutions. Results are fed back to complainants. Staff are aware of the complaints which have been discussed at staff meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyers of the facility. The service can provide information in different languages and/or in large print if</p>

		requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service a registered nurse (RN) or the clinical manager discusses the information pack with the resident and the family/whānau.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. The staff were observed to respect residents' privacy and dignity by closing doors when carrying out personal care. Residents were observed to have call bells placed within reach when left unattended in their room or bathroom.</p> <p>Residents interviewed reported that staff respected their privacy and dignity when carrying out personal care. Staff described how they manage maintaining privacy and respect of personal property.</p> <p>There is a policy that describes spiritual care. Church services are conducted in the facility every week. All residents and relatives interviewed indicated that residents' spiritual needs are being met when required.</p> <p>Staff are familiar with the policies and appropriate practices around the prevention and identification of abuse and neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to meet the cultural needs of its residents. There is a Māori health plan.</p> <p>Staff training includes cultural safety. The service can access Māori advisors as identified in the Māori health plan and policies. Where residents identify as Māori; specific service and cultural needs are addressed in their care plan.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and</p>	FA	<p>The service has established cultural policies aimed at meeting the cultural needs of its residents. All residents and relatives interviewed report that they are satisfied that their cultural and individual values are</p>

respect their ethnic, cultural, spiritual values, and beliefs.		being met. Information gathered during assessment including residents cultural beliefs and values is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff received education on cultural safety and awareness in October 2016.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	The facility has a staff code of conduct which states there will be zero tolerance against any discrimination. The clinical manager and registered nurses supervise staff to ensure professional practice is maintained. The abuse and neglect process covers harassment and exploitation. All residents interviewed report that the staff are respectful and considerate. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service has policies to guide practice that align with the Health and Disability Services Standards to meet the needs of residents requiring rest home and hospital level of care. Staffing policies include pre-employment checking and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey reflects overall satisfaction with the services that are provided. Residents and relatives speak very positively about the care and support provided. Staff interviewed have a sound understanding of principles of aged care and state that they feel supported by the management team.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fourteen incidents/accidents forms were viewed. The form includes a section to record family notification. All forms indicate family have been informed or if family did not wish to be informed. Relatives interviewed report that they are notified of any changes in their family member's health status.

<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>Mossbrae Healthcare is a privately-owned facility. The facility has 64 beds; on the day of the audit there were 59 residents. There were four residents at rest home level, including one on an exceptional circumstances (respite care) contract, and 55 residents at hospital level care. All 64 rooms are dual-purpose to accommodate hospital or rest home level of care residents. The facility has a business, quality and risk management plan which has specific annual quality goals identified that link to the business plan and are reviewed quarterly.</p> <p>The facility manager is an experienced manager (registered nurse) and has managed the facility for two years. A clinical manager (RN) has been in the role since May 2016, and supports the facility manager. There are job descriptions for both positions that include responsibilities and accountabilities. The facility manager advised that the owners visit at least monthly and are available to be contacted by email or telephone at any time. A weekly management report is completed by the facility manager and forwarded to the owners. The manager and clinical manager maintain at least eight hours annually of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the facility manager the clinical manager is in charge with support from the owners and care staff.</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>The quality programme includes the service philosophy, general objectives and lists the quality activities. An annual quality plan for 2017 has been developed and is being implemented. An internal audit schedule is in place. Corrective actions have not been consistently developed where compliance is less than expected. Discussion of quality data is documented in the meeting minutes reviewed for staff, health and safety/infection control (IC), RN/clinical and resident meetings. Resident meetings are held with follow-up of issues and discussions documented. The external catering company representative attends all residents' meetings.</p> <p>There is a document control policy and all policies and procedures are</p>

		<p>reviewed regularly. Documents no longer relevant to the service are removed and archived.</p> <p>A resident survey and a relative survey was last conducted in February 2016 with respondents advising that they are overall very satisfied with the care that residents receive. Issues identified in the survey have been addressed with corrective actions implemented.</p> <p>The service collects information on resident incidents and accidents as well as staff incidents/accidents. The service has a health and safety management system and hazard registers are documented. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency.</p> <p>There is an infection control manual, infection control programme and corresponding policies. There is a recently reviewed restraint minimisation policy and health and safety policies and procedures. There are procedures to guide staff in managing clinical and non-clinical emergencies. Falls prevention strategies are implemented.</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>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical manager and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings, health and safety/IC and RN/clinical meetings, including actions to minimise recurrence. Fourteen incident forms sampled from February 2017 document clinical follow-up of residents is conducted by a registered nurse. Discussions with the facility manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</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>	<p>PA Negligible</p>	<p>There are human resource management policies in place which include that relevant staff checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Eight staff files selected for review included the facility manager, clinical manager, one cleaner, one diversional therapist, two caregivers, one enrolled nurse and one registered nurse. The files evidence that the required documentation including orientation, and annual performance appraisals are all completed as required. Two</p>

		<p>staff were new to the service and annual appraisals were not required.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2016 has been completed and the 2017 programme is being implemented. The service has recently introduced a “back to basics” education programme for caregivers. Three education sessions have been held and feedback from staff has been positive. The clinical manager and registered nurses can attend external training including sessions provided by the local DHB.</p> <p>The service has experienced delays in accessing InterRAI training for registered nursing staff. There are two of seven registered nurses on staff who are InterRAI trained and have maintained competency. One of the two InterRAI trained registered nurses works permanent night duty shifts. The service has been trying to reserve places on InterRAI training for one year for a further two staff members and have just recently been allocated training places. InterRAI assessments have not been completed within the required timeframes due to the lack of access to training.</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>	<p>FA</p>	<p>Policies include staff rationale and skill mix. Sufficient staff are rostered on duty to manage the care requirements of the residents.</p> <p>In Inglis wing, there is an RN rostered on duty on each shift seven days a week</p> <p>In Argyle wing, there is an enrolled nurse rostered on duty Monday – Friday morning and an RN is rostered to cover the weekend morning shifts. A registered nurse is rostered on duty each afternoon seven days per week. The RN rostered on night duty in Inglis wing covers both wings.</p> <p>Each wing has five caregivers each morning shift, the afternoon has two long shifts and three short shifts. At night, there are two caregivers (one based in each wing).</p> <p>The clinical manager (registered nurse) works 72 hours per fortnight Monday – Friday. The facility manager is also a registered nurse and works full time Monday – Friday. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of</p>

		residents.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant caregiver, enrolled or registered nurse. Individual resident files demonstrate service integration. This includes medical care interventions and records of the diversional therapist. Medication charts are in separate folders.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is a policy for resident admissions that includes responsibilities, assessment processes and timeframes. Needs assessments are required for entry to the facility. Mossbrae Healthcare communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. There is an information pack provided to all residents and their families on the service provided. The pack includes all relevant aspects of service delivery and residents and/or family/whānau are provided with associated information such as the Code of Consumer Rights, complaints information, advocacy, and admission agreement. Family and residents interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service. Signed service agreements are signed for eight resident files sampled.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has transfer and discharge procedures. The procedures include a transfer/discharge form and the completed form is placed on file and retained as part of the archived resident records. The clinical manager verbalised that telephone handovers are conducted for all transfers to other providers. The residents and their families are involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA	<p>Medication policies align with accepted guidelines. The RNs and</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>Moderate</p>	<p>caregivers responsible for the administration of medications have completed annual competencies and medication education. A signed medication reconciliation form evidences medications are checked on arrival by the registered nurse. Any pharmacy errors recorded are fed back to the supplying pharmacy. Standing orders are in use and reviewed annually by the GP for individual residents. There were no residents who self-administer medications. Medications requiring refrigeration are stored in a designated fridge in each of the two wings. The fridge temperature in each wing is monitored daily and is maintained between 2-8 degrees Celsius. The medication round sighted complied with medication policy and procedure. All medications are stored appropriately and eye drops are dated on opening. Oxygen cylinders are restrained in the treatment rooms. Sharps are disposed of into approved biohazard containers.</p> <p>Sixteen medication charts were reviewed. Medication charts (except one new admission) have photo identification and allergy status. Gaps were identified in the medication administration signing charts.</p> <p>The use of 'as required' (PRN) medications are monitored and signed with times when administered.</p> <p>Sixteen medication charts sampled (twelve hospital, four rest home) identify that the GP has seen and the reviewed the resident three monthly.</p>
<p>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.</p>	<p>PA Low</p>	<p>Mossbrae Healthcare has a contract with an external catering company to provide all meals. All food is prepared off site. The external food agency employs trained chefs and the menus are reviewed by a dietitian. The catering company has an "A" rating certificate awarded by Dunedin City Council. There is a summer and winter menu. Food is delivered to Mossbrae Healthcare in hot boxes, including morning and afternoon tea. There is a kitchen area in both wings where delivered food is transferred to bain-maries and then served to residents. Kitchen staff attended food safety training in October 2016. An update in food safety education is scheduled for April 2017. A representative from the catering company attends resident meetings for feedback.</p> <p>The catering company have provided the facility with a food services manual and food safety plan that ensures all stages of food delivery to</p>

		<p>the resident are documented and comply with standards, legislation and guidelines. Snacks such as bread, eggs, sandwiches, fruit, cheese and biscuits are available and stored on site. Fridge and freezer temperatures are recorded.</p> <p>Registered nurses or enrolled nurses complete the nutrition profile which includes: likes and dislikes of the resident, and other special requests such as special diet requirements. This is faxed to the kitchen and alternatives are sent accordingly. There is a whiteboard in the serving kitchen with resident's special dietary profiles. This can be viewed only by the kitchen staff. Special diets being catered for include: pureed diets and soft diets. Kitchen areas in both wings are clean and tidy. Staff are compliant with wearing hats. Storage areas are tidy and nothing is stored on the floor.</p> <p>Food found in fridges is not always labelled and dated and fridge temperatures are not consistently recorded. Decanted food does not always have an expiry date.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The service has a process for declining entry should that occur. This includes informing persons and referrers (as applicable) the reasons why the service has been declined. The reason for declining service entry to potential residents is recorded and communicated to the potential resident/family/whānau. The reason for declining would be if the client did not meet the level of care provided at the facility or there are no beds available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>An initial nursing assessment and initial care plan is completed within 24 hours of admission. There are a range of assessment tools completed on admission and reviewed six monthly if applicable including (but not limited to): a) continence, b) pressure area risk assessment, c) nutrition d) falls risk assessment, e) pain assessment, f) behaviour assessment and monitoring. The InterRAI assessment tool was not completed within expected timeframes in two of eight resident files sampled (link 1.2.7.5).</p> <p>Assessments are conducted in an appropriate and private manner. All residents interviewed are very satisfied with the support provided. Outcomes from completed assessments are communicated to staff at handover. Resident and families advise that they are informed and</p>

		<p>involved in the assessment process.</p> <p>The general practitioner completes a medical admission within two working days.</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>The initial care plan is developed from the initial nursing assessment and identifies the areas of concern or risk. The InterRAI assessment tool and paper-based assessments are being utilised for assessments and outcomes are reflected into the long-term care plans (link also 1.2.7.5.) Long-term care plans sampled were reviewed and updated in a timely manner. Short-term care plans are in use for changes in health status and include interventions and date of resolution. Examples sighted include: wounds, infections, and weight loss.</p> <p>All eight resident files reviewed have a care plan in place, and staff are aware of care needs for all residents. Not all care plans included interventions to support all assessed needs. Residents and families confirm they are involved in the development of long-term care plans. Staff members report they are informed about changes in the care plans. Resident files evidence integration with the inclusion of allied health care notes and correspondence to and from referral agencies and hospital departments.</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, 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 (eg, to the district nurse, hospice nurse or wound specialist nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies. Sufficient continence products are available. Specialist continence advice is available as needed and this could be described</p> <p>The interventions in managing acute health issues including wounds are documented on short-term care plans and transferred to the long-term care plan (LTCP) if not resolved within six weeks. Interventions are updated when the desired goals/outcomes are not met or when the resident's response to the treatment is not satisfactory (link 1.3.5.2).</p> <p>Current resident wounds include: twelve ulcers, two grazes, one stage one pressure injury and one skin tear. Wound assessment forms and</p>

		<p>ongoing assessment and treatment forms were not fully completed for all wounds.</p> <p>Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. Families confirmed they are kept informed of any changes to resident's health status. Resident files reviewed included communication with family records.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities coordinator is a qualified diversional therapist. The activities coordinator has been working in this role for over two years and works five hours per day; Monday to Friday. In the absence of the activity coordinator the caregivers deliver the activity programme at the weekends. There are resources available such as quizzes, games, movies and crafts which the caregivers and residents can access.</p> <p>An activities assessment is obtained on admission and a plan is developed to meet the interests, needs and ability of each resident. The activity plan is reviewed six monthly in line with the resident's care plan review/evaluation. There is a monthly programme developed with input and suggestions from residents provided via the residents monthly meeting. The monthly programme is displayed on noticeboards in each wing. The programme contains a range of individual and group activities. Activities planned for the day are displayed on noticeboards around the facility. Activities occur in the conservatory and lounge areas. There is a wide range of activities offered that reflect the resident needs including but not limited to: knitting group, newspaper reading, visiting other facilities, quizzes, outings, bingo, fortnightly entertainment, music and one-on-one visits. Residents are encouraged and assisted to attend the activities that is appropriate and meaningful to them. Activities meetings are held bi-monthly. Mossbrae Healthcare has its own van for transportation which is used to access events in the community and those occurring at other local aged care facilities.</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 long-term care plan is reviewed at least six monthly or as changes occur as sighted in all eight care plans reviewed. Six monthly multi-disciplinary (MDT) reviews occur involving the GP, RN, caregiver and relevant allied health professionals involved in the resident's care. The interventions in both long-term and short-term care plans are modified</p>

		when the outcomes are different from expected. Recent reassessments have been completed using InterRAI tool. Residents and relatives interviewed report they were involved in all aspects of care including reviews/evaluations of the care plans. The family are notified of GP visits and if unable to attend, they are informed of any changes by the RN. The GP examines the residents at least three monthly and reviews the medication chart.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other medical and non-medical services. The registered nurses interviewed confirm that residents, family and GP are informed of any referrals made directly to other nursing services or the needs assessment team. Referrals to specialists are made by the GP. Referral forms and documentation are maintained on resident files as sighted (dietitian).</p> <p>Relatives and residents interviewed state they are informed of referrals required to other services and are provided with options and choice of service provider.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>There are policies in place in for waste management, waste disposal for general waste and medical waste management. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals are stored securely. Sluice rooms are locked. Bulk chemicals are stored in a locked storage area. Product use charts are available. The hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. There are approved sharps containers for the safe disposal of sharps. Protective equipment is to be worn and is accessible. Staff receive education in chemical safety.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building displays a current warrant of fitness which expires in 19 June 2017. There are two wings and each wing has a large communal lounge and dining area with other small sitting areas. In the Argyle wing, there are 31 single rooms and in Ingles wing, there are 31 single rooms and two double rooms which currently have single occupancy. The double rooms have privacy curtains and two call bell points. The facility employs a full-time maintenance person. There are proactive and reactive maintenance management plans in place. The owner, who is a qualified electrician, tests the electrical equipment. Electrical</p>

		<p>testing of non-hard wired equipment was last conducted on 6 March 2017. Medical equipment requiring servicing and calibration was last conducted on 6 March 2017. There are hazard management systems in place to ensure the physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the residents and any visitors to the facility. The facility manager advised that a refurbishment programme is in place, where when a room becomes vacant it is repainted and flooring, curtains and furnishings (where required) are replaced. Residents have adequate internal space to meet their needs. External areas are safe and well maintained. The facility has a van available for transportation of residents. Those transporting residents hold a current driver's license and a current first aid certificate.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate toilets and showers for residents. There are adequate communal toilets available. Separate visitor and staff toilet facilities are available. Water temperatures are monitored and temperatures are maintained at or below 45 degrees Celsius. Recently water temperatures have been above the recommended temperature range, immediate corrective action was evidenced to be implemented. (Plumbing records and corrective actions sighted). Fixtures fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Resident rooms are spacious. Walking frames, wheel chairs and hoists can be manoeuvred around the bed within the rooms, if required. Residents requiring transportation between rooms or services can be moved from their room either by trolley or by wheelchair.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Each unit has a large lounge and dining area. The dining rooms are located close to kitchen/servery area. There is a large conservatory area which can also be used for activities. There are smaller lounge areas available which can be used for quiet activities such as reading or for spending private time with family or friends. Residents were seen moving around freely between the areas. There are outdoor seating areas with shade.</p>

<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There is a separate laundry area responsible for laundering all linen and personal clothing. In the laundry, there are clearly marked areas to delineate and define the clean and dirty laundry spaces. Mossbrae Healthcare has designated laundry and cleaning staff who have attended chemical training and infection control training. Chemicals are clearly labelled and adequately stored. Manufacturer's data safety charts are available. Personal protective equipment is easily accessible. The internal auditing system and the satisfaction surveys monitor cleaning and laundry services.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>There is an approved fire evacuation scheme dated 8 July 2005 in place. Fire evacuation drills are held at least six monthly. The last fire drill was completed November 2016. There is a civil defence and emergency procedures manual in place. The civil defence kit is readily accessible in a designated storage cupboard. The kit includes an up-to-date register of all residents' details. The facility is prepared for civil emergencies and has emergency lighting and BBQs. An emergency food supply, sufficient for three days, is kept in the kitchen. Water is contained in storage tanks. Extra blankets are also available. Hoists have battery packs and there are batteries that can be used to operate electric beds in the event of a power failure. There is a list of names and contact details of staff so that they can easily be contacted in an emergency. The facility is secured during the hours of darkness. Staff are security conscious. Appropriate training, information, and equipment for responding to emergencies is provided. Staff training in emergency management occurs. The call bell system is available in all areas and there are indicator panels in each area. During the tour of the facility residents were observed to have easy access to the call bells. Two residents were observed to have sensor mats in place. Residents interviewed stated that their bells are answered promptly.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>The facility is light and airy and able to be ventilated by opening external windows and doors. There is electric heating with some heat pumps located in public areas. Internal temperatures are monitored and regulated by the maintenance person. There is a sheltered designated smoking area outside, which is used by residents who are smokers.</p>

<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>Mossbrae Healthcare has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. A registered nurse is the designated infection control coordinator with support from the clinical manager. Minutes are available for staff. Infection control audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation. The infection control programme has been reviewed annually. There have been no outbreaks since previous audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>A registered nurse is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC nurse and IC team has good external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred in October 2016. The infection control coordinator has completed infection control training and continues to keep updated by attending external education sessions and attending the SDHB Infection Control Forum Meetings. (Meeting minutes were sighted confirming attendance). Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is</p>

		appropriate to their needs and this is documented in medical records.
<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 the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. 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. Outcomes and actions are discussed at the combined health and safety/infection control meetings, RN/clinical and staff meetings and results posted for staff to view. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the clinical and facility manager.</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 are ten residents requiring the use of an enabler (bedrails). Enabler use is voluntary.</p> <p>There are seventeen residents requiring the use of a restraint. Fourteen bedrails and three lap belts when in wheelchairs or shower chairs.</p> <p>All necessary assessments and evaluations had been completed in relation to the restraints. Staff interviews and staff records evidence guidance has been given on: restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0 and have been recently updated. The service has also undertaken a review of all residents with restraint as part of an ongoing process to reduce the use of restraint in the facility.</p> <p>Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of the health and safety, RN and staff meetings. The facility manager (registered nurse) is the designated restraint coordinator.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and</p>	FA	<p>The facility manager is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner.</p>

procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau in the three restraint files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner have been involved in the assessment and consent process. In the three restraint files and two enabler files reviewed, assessments and consents are fully completed.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	PA Low	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified. The facility manager advised that a comprehensive review of all residents requiring the use of a restraint is in progress in consultation with the GP and family members. Purchasing of some ultra-low beds, perimeter guard mattresses and protective shock absorbing landing mats is currently in progress to try and minimise the continuing need for restraint. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed have a completed assessment form and a care plan that reflects risk but do not consistently document the frequency of monitoring required to minimise the risk of harm to the resident. Monitoring forms do not consistently document when monitoring has occurred. The service has a restraint and enablers register which is up-to-date.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The service has documented evaluation of restraint every six months. In the restraint files reviewed, evaluations have been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at clinical management/quality meetings. Evaluation timeframes are determined by policy and risk levels.
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their</p>	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any

use of restraint.		adverse outcomes are reported at the monthly health and safety and staff and RN meetings and reported in the weekly management report to the owners.
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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	The facility captures quality data. Where areas requiring improvements have been noted, corrective action plans are not consistently evidenced to be completed.	Internal audit results that identify areas of non-compliance do not consistently include a corrective action plan.	<p>Ensure corrective action plans are completed and evaluated to demonstrate achievement of compliance with the desired outcome</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 providers to provide safe and effective services to consumers.</p>	PA Negligible	There are two RNs who have completed InterRAI training, one works permanent night duty shifts. The service has experienced delays in accessing InterRAI training for a further two registered nurses.	The service has experienced delays in accessing InterRAI training for registered nursing staff, therefore InterRAI assessments have not been completed within the required timeframes.	<p>Ensure InterRAI training is accessed to enable registered nurses to complete assessments within the required timeframes.</p> <p>180 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>Regular medications are prescribed correctly. 'As required' medications have 'indications for use' prescribed on the medication chart. Medication charts have been reviewed by the GP three monthly. Standing orders are reviewed by the GP annually. The pharmacist completes a weekly stocktake of medications with the RN. Gaps were identified in medication signing sheets.</p>	<p>Seven of sixteen medication signing sheets identify that medication has not always been signed as administered.</p>	<p>Ensure medication signing sheets document the administration of prescribed medications.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	<p>PA Low</p>	<p>Mossbrae Healthcare has a contract with an external catering company to provide all meals. All food is prepared off site. The external food agency employs trained chefs and the menus are reviewed by a dietitian. The catering company has an "A" rating certificate awarded by Dunedin City Council. There is a summer and winter menu. Food is delivered to Mossbrae Healthcare in hot boxes, including morning and afternoon tea. There is a kitchen area in both wings where delivered food is transferred to bain-maries and then served to residents. Food temperatures are monitored prior to leaving the catering kitchen and then prior to serving. Fridge temperatures have not been consistently recorded. Not all food stored in fridges is labelled and dated. Dry food stores decanted in to containers are labelled but do not always include an expiry date.</p>	<p>(i) Fridge temperatures are not evidenced to be consistently recorded.</p> <p>(ii) Food found in fridges is covered but not dated.</p> <p>(iii) Decanted dry food stores are labelled but do not document an expiry date.</p>	<p>(i) Ensure fridge temperatures are recorded as per policy.</p> <p>(ii) Ensure all food is labelled and dated.</p> <p>(iii) Ensure all decanted food has an expiry date documented.</p> <p>60 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>All eight resident files reviewed have a care plan in place, and staff are aware of care needs for all residents. Not all care plans included interventions to support all assessed needs.</p>	<p>(i) One resident with challenging behaviour did not have de-escalation techniques documented to support all behaviours that challenge. (ii) One resident with an indwelling catheter did not have interventions documented to manage all aspects of catheter care. (iii) Two residents with weight loss did not have interventions documented to support management of the weight loss.</p>	<p>Ensure that long-term care plans include interventions to manage and support all assessed needs</p> <p>60 days</p>
<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 Moderate</p>	<p>Individual wound assessment, treatment and evaluations are completed for each wound. Four of eight wound assessments, wound management plans and evaluations reviewed are fully completed.</p> <p>The service has templates for a range of monitoring. Monitoring forms and progress notes reviewed do not evidence that interventions prescribed in care plans in relation to pressure injury prevention and monitoring of food and fluid intake are completed.</p>	<p>(i) Four of eight wound assessment, treatment and evaluation forms do not document achievement towards the wound healing process with each dressing change.</p> <p>(ii) Three of eight wound charts have multiple wounds documented on one assessment chart.</p> <p>(iii) Monitoring charts were not evidenced in use to reflect food and fluid intake for those identified at risk of malnutrition or record the frequency of pressure injury prevention interventions implemented. This information was also not documented in progress notes.</p>	<p>(i) Ensure the plan for each wound monitors progress towards the wound healing process.</p> <p>(ii) Ensure all wounds are assessed individually and documented on an assessment form per wound.</p> <p>(iii) Ensure monitoring charts or progress notes are completed to reflect monitoring and implemented care.</p> <p>60 days</p>
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account</p>	<p>PA Low</p>	<p>Two of seven restraint files sampled include monitoring requirements (both two hourly) on the monitoring form and in the care plan. Interviews with caregivers evidences</p>	<p>(i) Five of seven restraint care plans reviewed do not document the frequency of monitoring required when restraint is in use.</p>	<p>(i) and (ii) Ensure the frequency of monitoring required when restraint is in use is documented in the care plans and ensure</p>

<p>of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome;</p> <p>(b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;</p> <p>(c) Details of any advocacy/support offered, provided or facilitated;</p> <p>(d) The outcome of the restraint;</p> <p>(e) Any injury to any person as a result of the use of restraint;</p> <p>(f) Observations and monitoring of the consumer during the restraint;</p> <p>(g) Comments resulting from the evaluation of the restraint.</p>		<p>an understanding of the requirements to document when monitoring of a resident using a restraint has occurred. The sample of incident reports reviewed was expanded and no events relating to resident harm while using a restraint were evidenced to be reported in 2016 or 2017 to date. Therefore, the risk has been assessed as low but the timeframe for corrective action to be completed has been shortened.</p>	<p>(ii) Monitoring of restraints when in use is not consistently documented.</p>	<p>that restraint monitoring occurs within the designated timeframes and that this is documented.</p> <p>30 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.