

Presbyterian Support Central - Woburn Elderly Care

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Presbyterian Support Central

Premises audited: Woburn Home

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

Dates of audit: Start date: 20 April 2017 End date: 21 April 2017

Proposed changes to current services (if any): This audit also included verifying as suitable to provide medical level care under their hospital certification

Total beds occupied across all premises included in the audit on the first day of the audit: 93



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Woburn is part of the Presbyterian Support Central Group (PSC) and provides rest home, hospital and dementia care for up to 105 residents. On the day of audit there were 93 residents. The service is managed by a facility manager, a clinical nurse manager and three clinical coordinators (one in each unit). The residents and relatives interviewed spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The service has addressed five of the six shortfalls from the previous certification audit relating to quality and risk management systems and human resource management. Improvements continue to be required in relation to the updating of consumers' service delivery plans. This audit has identified further improvements required around care plan interventions, planned activities, evaluation and medicine management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service ensures effective communication with all stakeholders including residents and families. Complaints processes are implemented and complaints and concerns are managed and documented.

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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PSC Woburn continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to the monthly senior team meetings. An annual resident satisfaction survey is completed and resident meetings are held. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

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.
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An information pack is made available to the resident and family/whānau prior to entry or on admission. Unit coordinators and/or registered nurses are responsible for each stage of service provision. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations within the required timeframes. Care plans are based on the interRAI outcomes and other assessments. Residents interviewed confirmed they were involved in the care planning and review process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

There are medicine management policies and procedures in place. General practitioners review residents at least three-monthly or more frequently if needed.

Meals are prepared on-site and the menu has been reviewed by a dietitian. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

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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A current building warrant of fitness is posted in a visible location.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had one resident using an enabler and eight residents assessed as requiring the use of restraint.

Infection prevention and control

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	4	1	0	0
Criteria	0	34	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice and this is communicated to resident/family. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaint register that records activity. Complaints are discussed at the monthly senior management team meeting and the two-monthly staff meetings. Information on making a complaint and the forms are visible around the facility. Eight documented complaints between August 2016 and March 2017 were reviewed. Follow-up communication, investigation and outcomes were documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The service has an open disclosure policy. Discussions with seven residents (four from the hospital and three from the rest home) and four family members (two hospital and two dementia) confirmed they were given time and explanation about services and procedures on admission. Eden circles for residents/relatives have commenced and there are now monthly events/meetings held with relatives with an annual formal meeting. The facility manager, clinical nurse manager and clinical coordinators have an open-door policy. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Eleven accident/incident forms sampled from February and March 2017 identify that family of ten residents were notified following a resident incident. There was documentation in the file of the eleventh resident indicating that the family had requested to only be informed</p>

<p>conducive to effective communication.</p>		<p>for some incidents. Interviews with five healthcare assistants (HCA), three registered nurses (RN), three clinical coordinators and three managers confirmed that family members are kept informed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Woburn Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home, hospital and dementia care levels for up to 105 residents (42 rest home, 43 hospital and 25 dementia). On the day of audit there were 93 residents (37 rest home residents- including 1 respite, 34 hospital residents- including 1 respite and 1 palliative respite and 22 residents in the dementia unit). There are 10 dual purpose beds; all are currently being used as rest home level.</p> <p>All residents were on the ARC contract. This audit also included verifying as suitable to provide medical level care under their hospital certification.</p> <p>Woburn has a 2016-2017 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, the Eden alternative and health and safety. Progress towards goals (and objectives) is reported through the manager reports and taken to the senior management team meeting.</p> <p>The facility manager on day of audit was an interim manager who will leave on commencement of a newly appointed facility manager. The new facility manager is due to commence in June 2017. The facility manager (clinical) is supported by an experienced clinical nurse manager and three care coordinators who have been in their roles for some years. The quality role is shared between the manager and clinical nurse manager. The facility manager is supported by a regional manager. A newly appointed regional manager will also be taking up this role in May 2017.</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</p>	<p>PA Low</p>	<p>PSC has an overall quality monitoring programme. The monthly and annual reviews of this programme reflect the service's ongoing progress around quality improvement. There is a schedule for internal audits and benchmarking between PSC facilities occurs. There is a meeting schedule including monthly senior management team meetings that includes discussion about accident and incident trends, internal audit outcomes, infection trends and complaints. There is a collated corrective action report which is updated monthly till corrective actions are complete. The collated corrective action report included actions arising from complaints and internal audits. The previous audit finding relating to 1.2.3.6 has been met. Meetings are held as per schedule. Quality data and analysis is shared with staff (placed on noticeboards) and corrective actions are signed out and evaluated for effectiveness. The manager and care nurse manager write a quality report which is distributed for all staff to read and note corrective actions required. However, a shortcoming was noted in the lack of specific corrective actions following an increase in the incidence of infections and high incidence of falls.</p> <p>Registered nurse meetings and Eden Alternative meetings have been held. Health and safety, infection control and</p>

<p>principles.</p>		<p>restraint meetings occur three-monthly.</p> <p>Meetings with residents/family are held monthly in a social setting with the formal resident/family meeting held annually.</p> <p>Infections and accidents/incidents are also being documented on an electronic database.</p> <p>The service has a health and safety management system and this includes a health and safety rep that has completed health and safety training. On day of audit, the role was being covered by the clinical nurse manager whilst another rep took lead of the committee. Input from the central office health and safety adviser was being received. Monthly reports are completed and reported to meetings and at the quarterly Health and Safety Committee meeting. Health & Safety meetings include identification of hazards and accident/incident reporting and trends. Emergency plans ensure appropriate response in an emergency. The previous audit finding relating to 1.2.3.9 has been met.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. A document control system is in place. The policy for the use of enablers aligns with the restraint minimisation and safe practice for the 2008 Health and Disability Sector Standards. The medication policy around timeframes for staff for medication competencies aligns with the Ministry of Health medication guidelines.</p> <p>Annual resident and relative satisfaction surveys have been completed as per company schedule which included an analysis and the development of corrective action plans.</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</p>	<p>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise, and debriefing.</p> <p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. This is able to be used for comparative purposes with fellow homes within the PSC group. Senior team meeting minutes include feedback on incident and accident data.</p> <p>Eleven accident and incident forms were reviewed. All identified follow up by a registered nurse, however, all neuro observations documented following an incident where the resident had hit their head, were not documented as completed as per policy (link 1.3.6.1).</p> <p>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications and evidence of this occurring was sighted on audit. A section 31 was submitted to the Ministry of Health in December 2016. The matter was referred to the coroner and subsequently closed.</p>

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<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources management policies in place, which include recruitment. Staff process requires that relevant checks are completed to validate the individual's qualification, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (one clinical nurse manager, one cleaner, one administrator, one chaplain and three HCA's). Six files contained a current position description (the newly appointed chaplains position was being finalised). All files contained employment agreements. A schedule had been put in place to catch up and maintain annual appraisals (an action to remedy a previous finding). Outstanding annual appraisals had been completed and the 2017 performance appraisal schedule was being adhered to. The service is using the PSC recently introduced orientation programme that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2017 is being implemented. The majority of HCA's have completed an aged care education programme. Staff attend annual compulsory study days which includes training around the Eden Alternative programme. The clinical coordinators and RN's are able to attend external training. Eight hours of education or in-service education has been provided annually. All individual records and attendance numbers are maintained. A schedule of which staff have attended education is maintained and follow-up action and sessions are offered to ensure all staff receive the required training. Ten of fourteen registered nurses are interRAI trained. There are thirteen healthcare assistants on the roster in the dementia unit and all have completed at minimum their Limited Credit Dementia programme.</p> <p>There is a manual of competencies available to be used as required. A number are mandatory (eg, handling and hand washing) and others are used as appropriate (eg, medication administration).</p> <p>Previous findings relating to 1.2.7 have been met.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager work full-time. Registered nurses cover each 24-hour period in the hospital area. Agency staff are used to provide cover for sickness if necessary. The HCA numbers per area are adequate. In the dementia unit, the clinical coordinator (RN) is rostered 40 hours per week plus there is additional RN support. Interviews with HCA's, residents and family members identify that staffing is adequate to meet the needs of residents. Staff levels and skill mix are meeting contract and industry norm requirements. Staffing levels are benchmarked against other PSC facilities.</p>

<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Twelve medication charts were reviewed (four rest home, four hospital- including one respite and four dementia). There are policies available for safe medicine management that meet legislative requirements. Not all medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed all resident's medication three-monthly and all allergies were noted.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>There are no standing orders in use and there were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperatures are recorded regularly and these are within acceptable ranges.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals at PSC Woburn are prepared and cooked on-site. There is a five-weekly seasonal menu which had been reviewed by a dietitian. A portable bain marie is used to deliver foods to the hospital and dementia dining rooms. The rest home meals are plated and served from the kitchen to the adjacent dining room. End cooked and holding food temperatures are recorded. Fridge and freezer temperatures are recorded.</p> <p>Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. Nutritious snacks are available 24-hours a day for residents in the dementia unit.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the unit coordinator or registered nurse initiates a review and if required, GP, nurse practitioner or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health.</p> <p>In the residents' files reviewed, short-term care plans were commenced with a change in health condition, but not all evaluated or linked to the long-term support plan (link 1.3.8.3).</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management</p>

<p>in order to meet their assessed needs and desired outcomes.</p>		<p>and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.</p> <p>Not all residents had interventions documented in the care plans to meet their assessed care needs. Not all interventions documented in the care plans were followed. Behaviour monitoring forms are used (sighted) which described types of behaviour, possible triggers and the strategies for de-escalation that were used. The monitoring charts are reviewed by the registered nurse. The GP or nurse practitioner initiates specialist referrals to the mental health services.</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>	<p>PA Low</p>	<p>The recreational team provide individual and group activities in the rest home, hospital and dementia care units seven days per week. The recreation programme is supported by a team of volunteers. The service has achieved two Eden principles (two and ten) and is looking to achieve additional principles (three - six) over the next twelve months.</p> <p>The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The residents were observed participating in group and individual activities during the audit. Participation in the group programmes is voluntary. There are regular outings/drives for all residents (as appropriate) and involvement in community events. One-on-one activities occur for residents who are unable or choose not to be involved in activities. The programme is displayed on noticeboards in all units.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate) and a recreational plan is developed. Where recreational plans were sighted, these had been reviewed six-monthly at the same time as the care plans were reviewed. In the dementia files sampled, the recreational plans did not cover the 24-hour period.</p> <p>The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families.</p> <p>Relatives and residents stated they were satisfied with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan is evaluated at least six-monthly or earlier if there is a change in health status. There was at least a three-monthly review by the GP or nurse practitioner. Reassessments have been completed using interRAI LTCF and other relevant assessment tools for residents who have had a significant change in health status. Not all care plans were updated following a change in care level. Short-term care plans were in use. However, the short-term care plans were not all evaluated and where required, the interventions added to the long-term care plan. The previous audit finding related to evaluations remains.</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 holds a current building warrant of fitness, which expires 22 June 2017.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement. Corrective actions were not documented or implemented where infection rates were above the acceptable benchmark (link 1.2.3.8). Infection control internal audits have been completed. Trends are identified and quality initiatives are discussed at staff meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>There have been no outbreaks since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a restraint minimisation and safe practice policy applicable to the service that complies with the Restraint Minimisation and Safe Practice Guideline 2008. The organisational policy for restraint minimisation and enabler use ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register.</p> <p>On the day of audit, there were eight hospital residents using restraints (three lap belts and five bedrails) and one resident using an enabler (bed rail). Documentation was reviewed for the nine residents on restraint and enabler and evidences assessment, authorisation, consent, planning, monitoring and review of the devices and aligns with the policy guidelines.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Clinical data (falls, incidence of UTIs, respiratory infections and wounds) is collected, benchmarked with PSC facilities and shared with staff. Data is provided to staff at meetings and in report format and covers areas requiring improvement (eg, corrective actions arising from audits relating to interRAI (updating) and all staff attending mandatory education).	Where the incidence of falls and infection rates (UTIs, respiratory, wounds) were above the benchmark, corrective actions were not consistently documented or implemented. Incidence rates are provided to staff in report and graph form.	<p>Where opportunities are identified for improvements, ensure that corrective actions are documented and implemented.</p> <p>90 days</p>
Criterion 1.3.12.6	PA Low	The GP or nurse practitioner prescribes the medication for	Two of two residents on Warfarin had the variable daily dose individually charted and then bracketed and group signed by the	Ensure that all medication is

<p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>		<p>each resident. There were two residents on anticoagulant therapy, who had a variable dose charted orally over a 30-day period, that was bracketed and group signed by the GP.</p>	<p>GP.</p>	<p>prescribed according to guidelines and legislative requirements.</p> <p>60 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>Assessments are completed on admission, when the support plan is reviewed and with a change in health condition. The care plan is updated based on these assessments. In the files sampled, not all care plans had been updated following a change in health condition and not all interventions for assessed care needs were being documented or documented in sufficient detail to guide the care staff. Not all required monitoring was being completed. The sample size was extended for residents on hourly monitoring and this evidenced that their required monitoring was not being completed.</p>	<p>(i) In six of six (two rest home, two dementia and two hospital-including one respite) resident files sampled, interventions were not documented or not documented in sufficient detail to support care for: a) one hospital resident (hospital tracer) did not have interventions documented in sufficient detail for the management of a high falls and high pressure injury risk; b) one hospital resident with type II diabetes on insulin with fluctuating blood sugars, had no emergency diabetic management plan documented; c) one resident in the dementia unit with a 5 kg weight loss over 3 months and had no interventions documented to manage this weight loss (dementia tracer); d) interventions in use were not documented for one resident in the dementia unit using a specialist cushion and no interventions were documented for the management of glucose intolerance; e) one rest home resident with a history of a gastric ulcer and previous GI bleed had no interventions documented to monitor for this (rest home tracer); f) one rest home resident with a history of wandering off-site did not have interventions documented in sufficient detail to guide the care staff and the required half hourly monitoring was not consistently documented.</p> <p>ii) In three of five files sampled (one rest home and two dementia), the required monitoring as documented in the care plans was not consistently evidenced for: a) one rest home resident with a history of constipation; b) two dementia residents on monthly weighs; and c) five of five rest home residents (sample size extended) on hourly monitoring for position and or location checks.</p>	<p>i) Ensure that interventions are documented for all assessed care needs, in sufficient detail to guide the care staff and that all interventions in use are documented.</p> <p>ii) Ensure that all required monitoring is completed and documented.</p> <p>iii) Ensure that neurological observations are completed for all unwitnessed falls as</p>

			iii) Five of five hospital residents (from the random sample of accident and incident forms) who had an unwitnessed fall where it was suspected the resident may have hit their head, did not have neurological observations completed for the timeframes required by the organisational policy.	required by the organisational policies. 60 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	The recreation coordinator completes the activity profile and 'tree of life' when the resident is admitted, in consultation with the resident and their family (as appropriate). A recreational plan is then developed for each resident and this is reviewed in conjunction with a review of the long-term care plan. There are separate group programmes for each service level and the residents can also join in the activities that are provided by the day programme. Not all residents in the dementia unit have a recreational plan documented for the 24-hour period.	Two of two resident files sampled in the dementia unit did not have a 24-hour recreational plan documented.	Ensure that all residents in the dementia unit have a 24-hour recreational plan documented. 90 days
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the	PA Low	The long-term care plans are updated at least six-monthly and evidence was sighted of multidisciplinary and family input into reviews of the care plan. InterRAI and other assessments are completed following a significant change in health	i) In three of six files sampled (two rest home and one dementia), the long-term care plan was not updated following a change in health condition, specifically: a) discontinuation of narcotic analgesia; b) a change in mobility; and c) an increase to two-person assistance for showering. ii) Three of six residents (two rest home and one hospital) did not have the short-term care plans evaluated and the interventions	i) Ensure the long-term care plan is updated following a change in care needs.

<p>service delivery plan.</p>		<p>condition. However, the care plans were not always updated following this assessment or a change in care needs. Short-term care plans were evidenced in use for acute changes in health condition. However, these were not always evaluated and signed out and where the event was ongoing, the interventions were not always added to the long-term care plan.</p>	<p>added to the long-term care plan for the management of wounds, infections and pain.</p> <p>iii) One dementia resident had an interRAI assessment completed for a change in care level on the 27 March and was assessed as requiring hospital level care on the 11 April. On the day of audit (9 days later), no changes had been made to the long-term care plan to reflect the increased care needs.</p>	<p>ii) Ensure that short-term care plans are evaluated and signed out and where required, the long-term care plan is updated.</p> <p>iii) Ensure that the long-term care plan is updated following a change in care level.</p> <p>90 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.