

# Kapsan Enterprises Limited - Chadderton Rest Home

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## 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 HealthShare 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:** Kapsan Enterprises Limited

**Premises audited:** Chadderton Rest Home

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

**Dates of audit:** Start date: 12 June 2017 End date: 13 June 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:** 17

# Executive summary of the audit

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## 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

This unannounced surveillance audit was conducted against the Health and Disability Service Standards and aspects of the service contract with the District Health Board. Chadderton Rest Home can provide rest home level care for up to twenty-three residents.

The audit process included the review of relevant policies, procedures; residents and staff files; observations and interviews with residents, management and staff.

The managing director and clinical manager are responsible for the overall and clinical management of the facility.

Improvements identified at the previous audit have been addressed. Improvements are required to the following: documentation of assessments, care plans and review of care plans; documentation in the resident records by a registered nurse; minor repairs to a sink and the odour in one bedroom.

## 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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Staff interviewed are able to demonstrate an understanding of residents' rights and obligations including the complaints process. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident with this recorded in the resident file. Residents state that the environment is conducive to communication including identification of any issues.

## 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.		Standards applicable to this service fully attained.
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The organisation's mission statement and vision is documented. There is a current business, quality and risk management plan. Quality and risk management systems support service delivery and include internal audits, complaints management, resident and relative satisfaction surveys, and incident/accident management. Quality and risk management activities and results are shared among staff, residents and family.

Human resource policies include recruitment information, selection, orientation, staff training and development. Staffing levels meet occupancy and acuity levels and residents state that they have adequate access to staff when needed.

## 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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There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. Resident files sampled indicate that the resident is reviewed by the general practitioner monthly to three-monthly as required.

Planned activities are appropriate to the group setting. The residents interviewed confirm satisfaction with the activities programme.

There is a medicine management system in place with regular and as required medication administered as prescribed.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met.

## 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.		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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All building and plant comply with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes electrical checks and calibration of equipment. There have been no changes to the facility since the last audit.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. There are no restraints or enablers in use in the facility at the time of the audit.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection prevention and control policies and procedures are adequately documented. There is a designated infection control co-ordinator (clinical manager) who is responsible for ensuring monthly surveillance is completed.

## 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	13	0	1	3	0	0
Criteria	0	42	0	2	2	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>Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints. Complaints management is explained as part of the admission process and is part of the staff orientation programme and ongoing education. Residents and family confirm that management has an open door policy which makes it easy to discuss concerns at any time.</p> <p>The complaints register records the complaint, dates and actions taken. There are no outstanding complaints at the time of the audit and there have been no complaints to external authorities since the last audit.</p> <p>A review of two complaints confirms that the processes implemented meet the policy and the Code.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney and the resident of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure was available.</p> <p>Family contact is recorded in residents' files and this confirms that they are notified when there is an incident or accident. The communications record includes any visit or phone call.</p> <p>Interpreting services are available from the district health board. There are no residents requiring interpreting</p>

<p>communication.</p>		<p>services at the time of the audit. One resident who has English as a second language has staff who interpret and talk with them. They also have family who visit daily.</p> <p>The information pack is available in large print and this could be read to residents. Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident.</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>There are two owners who live close to the facility. One is the managing director who provides operational management and the other is the clinical manager (registered nurse). The owners have owned the facility since 2004. Either the managing director or the clinical manager is on site during the weekdays and weekends. The clinical manager has taken over the registered nurse responsibilities in the absence of the other registered nurse who resigned recently.</p> <p>The clinical manager has at least eight hours training relevant to the role, annually and has trained in interRAI. They also work two days a week in a private surgical hospital.</p> <p>There is a philosophy documented and residents and family are informed of the philosophy on entry to the service.</p> <p>The facility can provide care for up to 23 residents requiring rest home level of care. There were 17 residents in the service at the time of the audit, all confirmed by the clinical manager as requiring rest home level of care.</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>FA</p>	<p>Chadderton Rest Home has a quality and risk management framework that is documented to guide practice. There is a three-year business, quality and risk management plan that is reviewed annually and updated as changes occur. The managing director and clinical manager had previously delegated most internal audits to be completed by the registered nurse who documented action plans when issues were identified. The internal audits are now being completed by the managing director in the absence of another registered nurse. Service delivery is monitored through a review of resident file audits, complaints, incidents and accidents and the monthly analysis of data including surveillance on infections. The managers are responsive to needs within the organisation and have increased the number of resident file audits to quarterly to ensure that these are updated as required.</p> <p>There are monthly staff meetings and monthly managing director meetings held that include review and discussion of all aspects of the quality and risk management programme. There are quarterly to six monthly resident meetings with family able to attend if they choose to.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies having been reviewed as changes in legislation, best and</p>

		<p>evidence based practice are identified. The policies are developed and reviewed by an external consultant. Policies are available to staff and staff interviewed state that they read any new or revised policies.</p> <p>All staff interviewed including the caregivers, the diversional therapist and the cook report they are kept informed of quality improvements.</p> <p>The organisation has a comprehensive risk management programme in place that covers the scope of the organisation. Health and safety policies and procedures are documented. There is a health and safety audit completed six monthly with evidence that any issues documented on a corrective action plan and signed off as resolved. There is evidence that any hazards identified are signed off as addressed or risks minimised or isolated. The managing director states that they impress on all staff the importance of identifying any issues as soon as these arise so that they can be fixed immediately. Hazards and management of any risks is an agenda item at each staff meeting.</p> <p>There is an annual resident/family satisfaction survey and results documented from the 2016 surveys indicate that resident or family are happy with the service provided.</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>The managing director and the clinical manager are aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes and are supported through the open disclosure process. This was confirmed in interviews with staff and the clinical manager.</p> <p>Staff receive education at orientation on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event when the resident has family. Information gathered is regularly shared at the monthly staff meeting. Analysis of incidents and accidents occurs monthly with trends analysed.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>FA</p>	<p>The clinical manager holds a current annual practising certificate. The service also holds copies of annual practicing certificates of visiting health professionals for example the general practitioner, pharmacists and dietician.</p> <p>Staff files sampled included a signed contract that includes privacy and confidentiality. Staff complete an application form with referee checks completed prior to appointment. There is an annual appraisal process with</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>all staff having a current performance appraisal. First aid certificates are held in staff files along with other training records. An application form is completed in all files and records of referee checks are kept. The service is now completing criminal vetting for all staff and the previous requirement identified at the certification audit has been addressed.</p> <p>All staff undergo a comprehensive orientation programme that meets the educational requirements of the District Health Board Aged Residential Care (ARC) contract. Caregivers are paired with a senior caregiver for shifts until they demonstrate competency. Annual medication competencies are completed for all caregivers.</p> <p>There is a training plan implemented and attendance records kept for each staff member. Training is provided by external providers including the district health board and staff state that they find the training relevant to their needs with at least eight hours completed per year. Staff also state that they value the training around management of challenging behaviour.</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>There is a policy around staffing which is the foundation for work force planning. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.</p> <p>The managing director and the clinical manager are on call. Staff confirmed that the clinical manager is available at any time and they respond immediately if rung.</p> <p>There are 13 staff including the managing director, clinical manager, diversional therapist, household staff and caregivers. The clinical manager is on site during the week and over weekends. Residents confirm staffing is adequate to meet the residents' needs and all residents state that there are always sufficient staff on duty at all times.</p> <p>Rosters reviewed indicate that staff are replaced when a staff member is on leave. There is always at least one caregiver on duty at all times with a second caregiver on site during the day and afternoon. Staff are also able to be added to the roster in response to higher resident needs.</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</p>	<p>FA</p>	<p>A detailed medication policy documented is reflective of current safe practice guidelines. The policy identifies that staff who administer medicines must be competent. Caregivers and the clinical manager who administer medications have completed medication competencies for 2016-17 year. The caregiver observed administering the lunchtime medication complies with regulation requirements.</p> <p>Medicines are kept in a locked trolley with some oral medication and creams stored in a locked cupboard. A fridge is used to store medication with temperatures checked regularly.</p> <p>There are no residents requiring the use of controlled drugs. The clinical manager was able to describe a process for management of controlled drugs that included these being checked weekly by two staff. As required</p>

<p>guidelines.</p>		<p>medications are charted with documentation of indications for use and maximum dose per hour.</p> <p>One resident is self-administering some medication with a competency completed by the clinical manager confirming that the resident is able to self-administer medication as per the prescription. The inhaler is kept by the resident in their bedroom drawer. There is a notebook for the resident to record when they have had it and the clinical manager checks weekly.</p> <p>Medication records reviewed evidence photo identification on each resident record sheet with this confirmed as being a true and correct likeness. Any allergies or sensitivities are documented on the medical notes and the resident's medication record. All medications are prescribed individually and signed and dated by the GP. There is no evidence of any transcribing of instructions. The clinical manager checks the medication packs when received from the pharmacy with documentation of reconciliation maintained.</p> <p>All medications are current with expiry dates checked and any expired medication returned to the pharmacy when identified. The pharmacist completes an audit of the system and of medications every six months.</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>The rest home uses the summer/winter seasonal menu which has been reviewed by a dietitian in November 2014. There is a plan to review the menu again in 2017. Nutritional guidelines for older people are available and considered when the menu plans are developed.</p> <p>An individual dietary assessment (nutritional status) is expected to be completed on admission with review of this occurring six monthly and as changes occur (refer 1.3.3). Morning and afternoon teas are prepared in the kitchen and snacks are available over twenty-four hours. Residents are weighed on admission and evidence is seen of a process to monitor unexplained weight loss. This includes contacting the resident's GP and notifying the kitchen of extra dietary requirements. The food service is managed by a cook over seven days. Special diets can be arranged, for example puree, fortified fluids, vegetarian diets or gluten free diets.</p> <p>Evidence is sighted of meal planning; cleaning routines and audit requirements being completed. All staff have completed relevant food safety training. The cook reports that they are supported by management with the ordering and purchasing of food supplies and they were able to describe individual requirements of the residents. Foods are stored above floor level and the fridges and freezers are monitored on a daily basis.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in</p>	<p>PA Low</p>	<p>Residents' care plans evidence interventions, desired outcomes and goals of the residents (refer 1.3.3). The GP medical notes include reviews that have occurred three monthly or according to timeframes documented and any treatment required is confirmed by the GP as being carried out by staff in a timely manner. Residents confirm that resident's current care and treatment meets their needs. There is a relative/friend/healthcare professional communication record kept in the residents' files. This documents the date, method of</p>

<p>order to meet their assessed needs and desired outcomes.</p>		<p>communication, details of the communication and any comments or follow up required.</p> <p>Short term care plans are developed when required. They record the detail of information required. The clinical manager signs these off as completed when the issue is resolved in most cases. Progress against the short-term plan is recorded in the progress notes.</p> <p>There is a daily care monitoring record completed by the caregiver on duty and retained in the resident's file. The clinical manager or senior caregiver monitors to ensure all cares have been completed in a timely manner. Vital recordings are taken as per resident need and at least monthly. All resident files reviewed confirmed that residents are stable.</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>FA</p>	<p>The diversional therapist (DT) has an allocation of 40 hours in the service per week. The programme is planned with the residents having input through the resident meetings and on a one to one basis. The activities programme is displayed on a weekly/monthly calendar with individual assessments and plans documented by the DT. The DT completes monthly documentation of participation and there is a daily attendance register kept for each resident. Caregivers also support activities according to the activities programme when the DT is not present. Assessments and plans with evidence of review were sighted in all resident files reviewed.</p> <p>Regular exercises are provided and the programme includes intellectual activities, spiritual activities, input from external agencies and supported ordinary unplanned/spontaneous activities including celebrations. The programme is implemented ensuring the strengths, skills and interests of residents are maintained. Residents are encouraged to maintain activities in the community with some residents going to the library, some who walk and others who attend community activities.</p> <p>Residents report they are happy 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 Moderate</p>	<p>Periods in relation to care planning evaluations are documented. Residents confirm their participation in care plan evaluations.</p> <p>The residents' progress records are documented by the senior caregiver on each shift. The clinical manager is required to document at least weekly notes around each resident and increase documentation if issues arise; however weekly documentation has not occurred in 2017 as required.</p> <p>When resident's progress is different from expected, the RN contacts the GP as required. If the resident has family involved, they are notified of any changes in resident's condition with this confirmed by the clinical manager. The GP confirmed that the clinical manager makes contact whenever there is a change in a resident's needs with this occurring in a timely manner.</p> <p>There is recorded evidence of additional input from health professionals, specialists or multidisciplinary sources,</p>

		<p>if this is required.</p> <p>The care plan is evaluated six monthly with the care plan updated in response. A full care plan is re documented every year. The care plan is not always updated as changes in residents needs occur.</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>	<p>PA Moderate</p>	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date June 2017). There have been no building modifications since the last audit.</p> <p>There is a planned maintenance schedule implemented with the owners completing maintenance as required. There is some particle board around sinks that is exposed. One room has a strong odour and the owners are trying to address this.</p> <p>The areas are suitable for residents with mobility aids.</p> <p>Electrical safety testing occurs every two years and all electrical equipment sighted has an approved testing tag. Medical equipment is calibrated annually.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered.</p> <p>There are external areas with a veranda to the front and one to the rear, outdoor areas with shade and access to garden areas. Residents confirm that the environment is suitable to meet their needs.</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 evacuation scheme confirmed in a letter from the New Zealand Fire Service in 2015.</p> <p>Emergency management policies and procedures guide staff actions in the event of an emergency. Emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. An approved provider checks fire equipment monthly.</p> <p>Emergency supplies and equipment include food and water on site. The requirement around water in the event of an emergency identified at the previous audit has been addressed.</p> <p>Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking.</p> <p>The emergency evacuation plan and principles of evacuation are documented in the fire service approved fire evacuation plan. All resident areas have smoke alarms and a sprinkler system. Emergency education and training for staff includes six monthly trial evacuations and there is always a staff member on duty with a current first aid qualification.</p> <p>Appropriate security systems are in place with staff checking that the premises are secure at night. There are</p>

		<p>security cameras installed in communal areas and on the grounds for resident safety. Staff and residents confirm they feel safe at all times. Call bells are located in all resident areas. Residents confirmed call bells are answered within an acceptable timeframe. All residents are mobile and staff state that they seldom ring call bells. Call bells randomly checked on the day of the audit are displayed and answered in a timely manner.</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>The infection control coordinator (clinical manager) is responsible for the surveillance programme. Monthly surveillance data relating to number and type of infections is recorded and there is evidence the data being analysed and evaluated.</p> <p>Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events with these retained in individual resident files. Staff report they are made aware of any infections of individual residents by way of feedback from the clinical manager, through verbal and written handovers and through documentation in progress notes.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures on restraint minimisation and use of enablers are documented and there are links with the policy for managing challenging behaviour. These are accessible to guide staff actions related to restraint and enabler use.</p> <p>There is no evidence of restraint or enablers being in use at this facility. All monthly staff meetings for 2017 remind staff there is to be no use of restraint in the service.</p> <p>The service has a commitment to a 'non-restraint' policy, philosophy and appropriate use of enablers/restraint. Enablers are only used for safety reasons. Staff interviewed understood that the use of enablers is to be a voluntary and the least restrictive means to meet the needs of residents with the intention and/or maintaining of a resident's independence. Training records evidence training occurs at orientation and is ongoing. The clinical manager is the restraint co-ordinator.</p> <p>There is a gate at the front entrance that can only be opened through a key pad. The number of the key pad is on the gate and residents interviewed confirmed that they can freely go out of the gate.</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 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>The clinical nurse is completing specialised assessments including a falls assessment; pressure area assessment; continence and dietary assessments. These are all reviewed at least six monthly and as changes occur apart from the dietary assessment which at times is not reviewed in a timely manner along with the review of the care plan.</p> <p>The clinical nurse has training to complete interRAI assessments. InterRAI assessments are not yet being completed for new resident's or all others in a timely manner. The interRAI assessment and activities review does not occur at the same time as the review of the long-term care plan in all instances and a new plan is not re-written every six months. The clinical manager states that the second registered nurse has recently resigned and as a result, the timeframes for completing assessments have been delayed with the review of the activities plan not necessarily occurring at the same time as the interRAI assessment.</p> <p>Three of the resident records reviewed include an initial assessment completed in</p>	<p>Not all timeframes for service delivery have been met.</p>	<p>Ensure timeframes for service provision are met.</p> <p>90 days</p>

		<p>timeframes as per contractual specifications and two records included an initial plan completed in a timely manner. Initial long-term care plans were not always completed within the first three weeks of the resident being admitted to the service. These include the last two residents admitted to the service (both admitted within the last year).</p> <p>In summary, timeframes are not met as follows: three resident records do not include an initial assessment completed in a timely manner and two do not include an initial plan completed in a timely manner; the initial long-term care plans are not always completed within three weeks of the resident being admitted; InterRAI assessments are not always completed for new resident's or for others in a timely manner; dietary assessments are not always reviewed in a timely manner and the interRAI assessment and activities review do not always occur at the same time as the review of the long-term care plan.</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>	PA Low	<p>Short term care plans are documented for short term issues. These are not always signed off as resolved. The GP interviewed stated that the clinical manager and staff follow up on treatment plans and confirmed that short term issues are resolved.</p>	<p>Not all short-term needs are signed off as resolved.</p>	<p>Ensure that there is evidence of resolution of issues for short term needs.</p> <p>90 days</p>
<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	PA Moderate	<p>There is an expectation that a registered nurse records information on each resident record at least every 24 to 48 hours with the frequency increasing if resident issues are identified. The progress notes are reviewed by a registered nurse on an ad hoc basis.</p> <p>The care plan is not always updated as changes occur.</p>	<p>Resident's records are not always updated on a regular basis and as changes occur.</p>	<p>Ensure that resident records are updated on a regular basis and as changes occur.</p> <p>90 days</p>

<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>The owners request that staff inform them immediately issues are identified. There is some 'bubbled' and exposed particle board particularly around a sink in a bedroom and a strong odour in some areas with behavioural management plans in place to address this.</p>	<p>There is particle board that is not able to be cleaned effectively.</p> <p>There is a strong odour in some areas of the facility.</p>	<p>i) Rep air any particle board that is not able to be cleaned effectively.</p> <p>ii) Con tinue to address issues related to the strong odour.</p> <p>180 days</p>

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

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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
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End of the report.