

# Devonport Palms Retirement Limited - Devonport Palms Retirement Complex

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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 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:

<b>Legal entity:</b>	Devonport Palms Retirement Limited
<b>Premises audited:</b>	Devonport Palms Retirement Complex
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 15 May 2017    End date: 16 May 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	29



# 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

Devonport Palms provides rest home level care for up to 30 residents. There were 29 residents on the day of the audit. The service is managed by a facility manager (non-clinical) who is also the owner. The owner/manager is a member of the Cavell Group, which provides strategic governance and support to the service. The manager is supported by a clinical manager/registered nurse. The residents and relatives interviewed are positive about the care and supports 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 not yet completely addressed the two shortfalls from the previous certification audit around care plan documentation and medication management.

This surveillance audit identified that improvements are required in relation to care interventions, activities, maintenance and fire evacuations.

## 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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Residents and families interviewed report that they are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

## 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 quality process being implemented includes an internal audit programme, monitoring adverse events and a health and safety programme that includes hazard management. Quality and risk information is reported at staff meetings. Residents and family are provided with the opportunity to feedback on issues during resident meetings and via annual satisfaction surveys.

Human resources are managed in accordance with good employment practice and meet legislative requirements. An orientation programme is in place for new staff. An education and training programme is provided. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing. Caregivers, residents and family members report staffing levels are sufficient to meet residents' needs. The clinical manager is the registered nurse and covers on call when not on-site. There are adequate numbers of staff on duty to ensure residents are safe.

The residents' files are appropriate to the service type.

## 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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Residents and families receive an information pack on admission. The registered nurse completes admission assessments using the interRAI assessment tool. Care plans are developed in consultation with the resident and/or family input. Care plans demonstrate allied health input into the care of the resident. Care plans are reviewed at least six-monthly.

Medication policies reflect legislative medicine requirements and guidelines. All staff responsible for administration of medicines complete education and medicine competencies.

An activities programme is in place. The programme includes outings, entertainment and activities that meet the recreational preferences and abilities of the residents. Residents expressed satisfaction with the activities provided.

All food is prepared on-site. Residents' nutritional needs are identified and documented. Alternative choices are available for dislikes. Meals are well presented. Residents commented positively on the meals.

## 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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A current building warrant of fitness is posted in a visible location (21 January 2018).

## 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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There is a restraint policy that includes comprehensive restraint procedures. There are clear guidelines in policy, which include documented definitions of restraints and enablers that align with the definitions in the standard. There are currently no residents requiring enablers or restraints. Staff receive training on restraint minimisation and managing challenging behaviours.

## 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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The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, 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	12	0	2	4	0	0
Criteria	0	36	0	3	4	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>The service has a complaints management policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with six residents and two family members confirms that they understand the complaints process. They also confirm that the facility manager and clinical manager are approachable and readily available if they have a concern.</p> <p>There has been one complaint lodged with the Health and Disability Commission in 2016 which is still under investigation. There have been no complaints in 2017 (year to date). The complaints register includes all information and correspondence related to the complaint.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Ten accident/incident forms reviewed all document evidence of open disclosure. Family are kept informed of any accident/incident unless the resident has consented otherwise. Interviews with the clinical manager confirms family are notified following changes in health status. Family interviewed state they are kept informed.</p> <p>Quarterly resident meetings provide a forum for residents to discuss issues or concerns on every aspect of the service. Access to interpreter services are available if needed although have not been required.</p>

effective communication.		Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and can be read to residents who are visually impaired.
<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>	FA	<p>The service is owned and managed by a member of the Cavell Group. The Cavell Group is comprised of a group of independent aged care providers who share policies and provide collegial support while maintaining their independent businesses. A mission and philosophy of care are defined for the service.</p> <p>At the time of the audit, there were 29 rest home level residents living in this 30-bed facility that is dedicated to rest home level care.</p> <p>A strategic plan is in place for the Cavell Group. A quality plan that is specific to Devonport Palms links to the Cavell strategic plan and lists annual goals and objectives. These are regularly reviewed by the facility manager and clinical manager.</p> <p>The facility manager/owner has a background in management and is non-clinical. He keeps up to date with the aged care sector through regular attendance at Cavell Group director meetings and New Zealand Aged Care Provider forums. His professional development relating to the management of an aged care service exceeds eight hours per year. He is supported by an experienced clinical manager.</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>	FA	<p>A quality and risk management programme is in place. Interviews with the facility manager, clinical manager, two caregivers, one cook and one activities coordinator reflects their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, as evidenced in meeting minutes and discussions with staff.</p> <p>Quality data collected is collated and analysed. Quality data is regularly communicated to staff via staff meetings and at handovers.</p> <p>An internal audit programme is being implemented. Areas of non-compliance include the initiation of corrective action plans with corrective actions signed off to evidence their implementation. Staff interviewed confirmed that the results of audits and corrective actions are discussed at staff meetings and</p>

		<p>at handovers.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (facility manager) and review of health and safety documentation confirmed that legislative requirements are being met. The hazard register is regularly reviewed (last review February 2017).</p> <p>Falls prevention strategies are in place that include the identification of interventions to minimise future falls. Falls risk assessments are in place. A physiotherapist is available on an as-needed basis.</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>	FA	<p>Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. The resident is reviewed by the clinical manager or after hours by the senior care staff at the time of the event. Ten incident forms were reviewed. Not all required monitoring following an unwitnessed fall, had been documented (link 1.3.6.1). The five residents' files reviewed demonstrate that accident/incidents are also documented in the resident's progress notes.</p> <p>Discussions with the facility manager and clinical manager confirmed their 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>	FA	<p>There are human resources policies to support recruitment practices. The clinical manager's practising certificate is current. All five staff files randomly selected for review (clinical manager, caregiver, cook, activities coordinator and a cleaner) have relevant documentation relating to employment. Annual performance appraisals are completed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklist. Staff are able to describe the orientation process and report that new staff are adequately orientated to the service.</p> <p>There is an annual education plan being implemented that includes competencies that must be completed by staff. The clinical leader has completed interRAI training.</p> <p>There is a minimum of one care staff member with a current first aid certificate on every shift.</p>
Standard 1.2.8: Service	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>delivery. A full-time clinical manager/RN and the facility manager/owner (non-clinical) are on-site Monday to Friday. The clinical manager is available on call after hours. If the clinical manager is on leave, RN cover is provided by other facilities in Tauranga from within the Cavell group.</p> <p>On a morning shift, there is one team leader and a caregiver. On an afternoon shift, there are two caregivers (one long and one short) and on a night shift, there is one caregiver.</p> <p>Caregiving staff are responsible for laundry. Cleaning staff work five days a week. An activities coordinator is rostered on 0900 to 1530, Monday to Friday.</p> <p>Staff report that staffing levels and the skill mix are appropriate and safe. Residents and family interviewed advise that they feel there is sufficient staffing.</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 Moderate</p>	<p>Ten medication charts were reviewed. There are policies available for safe medicine management that meet legislative requirements. All medication charts sampled meet legislative prescribing requirements. The medication charts reviewed identify that the GP has reviewed all resident's medication three-monthly and all allergies are noted. Residents who are prescribed dietary supplements have these correctly prescribed by the GP and staff sign for these as they are administered. The previous finding related to the signing for the administration of dietary supplements has been met. The service advises that they are implementing an electronic medication management system in the coming month.</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 described 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. Not all eye medication is use is current.</p> <p>The standing orders in use does not comply with the Standing Orders Guidelines 2016. Not all medication checks are documented. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperature is recorded regularly and is within the 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</p>	<p>FA</p>	<p>All meals at Devonport Palms are prepared and cooked on-site. There is a four-weekly seasonal menu which had been reviewed by a dietitian. Meals are plated in the kitchen and delivered to the dining area. 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.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to</p>

<p>met where this service is a component of service delivery.</p>		<p>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 are satisfied with the food and confirm alternative food choices are offered for dislikes.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded. End cooked food temperatures are recorded. The dishwasher is checked regularly by the chemical supplier.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The service uses a care plan template that is individualised to meet the residents assessed care needs. In the files sampled, interRAI assessment outcomes and other relevant nursing assessment outcomes were not all transferred to the long-term care plans. The previous audit finding related to care planning has not been addressed.</p> <p>The long-term care plans reviewed did not describe the support required to meet all the resident's goals and identified care needs and not all sections of the care plan template had been completed. The care plans did evidence allied health involvement. Short-term care plans are in use for changes in health status.</p> <p>Residents and their family/whānau interviewed report that they are involved in the care planning and review process. Staff interviewed report they find the care plans easy to follow and are able to describe the care required for the residents.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>The caregivers follow the care plan and report progress against the care plan at least daily in the progress notes. Not all residents have the required monitoring documented for bowel activity or following an unwitnessed fall.</p> <p>If external nursing or allied health advice is required, the clinical manager will initiate a referral (e.g., to the wound care specialist nurse). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans are in place for the two residents with wounds. All wounds have been reviewed in the required timeframes. There were no residents with pressure injuries on the days of the audit. The care staff have access to specialist nursing wound care management advice through the Cavell Group and the district nursing service.</p> <p>Interviews with the clinical manager and the caregivers demonstrated an understanding of the</p>

		individualised needs of residents.
<p><b>Standard 1.3.7: Planned Activities</b></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>	PA Low	<p>There are two activity coordinators who provide a recreational programme Monday to Friday. The activity coordinators are supported by a qualified diversional therapist (DT) within the Cavell Provider Group and they attend the regional DT meetings. The activity coordinators have a current first aid certificate.</p> <p>The activity programme is planned a month in advance and all residents receive a copy of the programme.</p> <p>There are a range of activities to meet the recreational preferences and individual abilities including: word games, history, memorabilia, entertainment, craft, exercises and movies. One-on-one time is spent with residents who choose not to participate in the group programme. A mobility van is hired for outings and drives. Residents are encouraged to maintain community involvement and trips are arranged to the RSA. Interdenominational church services are held monthly.</p> <p>The activities coordinators complete an activities assessment on admission. Each resident has an individualised activity plan documented. Not all activity plans sampled had been reviewed six-monthly or against the stated goals.</p> <p>Resident meetings provide an opportunity for the residents to provide feedback and suggestions on the activity programme.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In the residents' files reviewed, all initial care plans are documented and evaluated by the clinical manager within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Evidence of three-monthly GP reviews are documented in all residents' files sampled. Ongoing evaluations occur daily/as indicated and are documented within the progress notes. Not all activity care plans had been reviewed as required (link 1.3.7.1).</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Moderate	<p>A current building warrant of fitness is posted in a visible location (expiry 4 December 2016). The facility manager coordinates all planned and reactive maintenance. The facility is well maintained, however, not all maintenance required in the kitchen has been completed. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. Residents have access to safely designed external areas that have shade. Staff state they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>PA Moderate</p>	<p>The orientation programme and education and training programme includes fire and security training and staff completing competency questionnaires. Staff interviews confirm their understanding of emergency procedures. Six-monthly trail fire evacuations could not be evidenced.</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>	<p>FA</p>	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. 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>	<p>FA</p>	<p>There is restraint minimisation and safe practice policies applicable to the service. Guidelines of the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. The clinical manager is the restraint coordinator and is knowledgeable regarding this role. During the audit, there were no residents using a restraint or an enabler. Staff receive training around restraint minimisation and managing challenging behaviours. Staff interviewed understands the difference between an enabler and a restraint.</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 1.3.12.1</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>	PA Low	<p>The service has documented policies and procedures for safe medication management. All staff who administer medication have completed the required medication competencies. Medication packs are checked by the clinical manager against the medication chart on arrival from the pharmacy. Medication is stored safely. Not all required medication checks have been completed. The eye drops in use on the medication trolley were reviewed and the eye medication in use was expired.</p>	<p>i) There was no evidence of weekly mandatory drug checks being completed.</p> <p>ii) One of one eye drops in use were expired.</p>	<p>i) Ensure all required medication checks are completed as required by contractual and legal requirements.</p> <p>ii) Ensure all medication in use has not expired.</p> <p>60 days</p>

<p>Criterion 1.3.12.6</p> <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>PA Moderate</p>	<p>The service uses standing orders. However, the standing orders in use do not consistently record the number of dose(s) of the medicine for which the standing order is valid, the contraindications and/or exclusions for the medicines, the monitoring of the medicine (if required,) the clinical documentation to be recorded and the standing order competency requirements.</p>	<p>The standing orders in use do not comply with the Standing Orders Guidelines 2016.</p>	<p>Ensure that the standing orders in use comply with the Standing Orders Guidelines 2016.</p> <p>30 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>The clinical manager completes the interRAI and other relevant nursing assessments. The clinical manager reviews the information gathered from assessments, monitoring charts, observations and interviews with residents, staff and families to develop the care plan. The information gathered in the assessment processes is not always transferred to the care plan, or used to document the required care plan interventions. Care plan interventions are not documented for two residents with a recent history of wandering.</p> <p>Not all sections of the care plan template had been completed. The outcome scores from the interRAI assessments completed, are not entered in five of five care plans sampled. This is a continued finding from the previous audit.</p> <p>There is evidence of the use of short-term care plans and these have been evaluated and signed out once resolved. Care staff are able to describe the care required for the residents.</p>	<p>i) Five of five care plans sampled do not have the interRAI assessment outcomes/scores transferred to the long-term care plans in relation to falls risk, pressure injury risk, and undernutrition and bowel management.</p> <p>ii) Five of five care plans sampled do not document care plan interventions for all assessed needs. Where care plan interventions were documented, they did not fully describe all support required. Examples include; management of: behaviours, an indwelling catheter, mobility, high falls risk, pressure injury risk, end of life care, confusion, spiritual or cultural care, reflux, chronic myeloid leukaemia, ulcerative colitis, pagets disease and hyponatraemia,</p> <p>iii) Two of two residents with a history of dementia and confusion, who have wandered off-site, do not have care plan interventions documented to manage this risk.</p> <p>iv) Three of five care plans sampled do not have the front sections of the care plan fully completed and do not document</p>	<p>i) Ensure that all relevant assessment scores/outcomes are transferred to the long-term care plan.</p> <p>ii-iii) Ensure that care plan interventions are documented for all assessed care needs and in sufficient detail to guide the care staff.</p> <p>iv) Ensure that all sections of the template care plan are completed fully.</p> <p>30 days</p>

			the required monitoring for weight and BP or have the allergies section completed.	
<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>The clinical manager reviews the assessment information gathered to document the interventions required in the care plan. The care plan describes the type and frequency of monitoring the resident requires. Two of five residents with a history of constipation have no monitoring of bowel activity documented. Five of five residents following an unwitnessed fall, do not have the post falls monitoring required by the organisational policy documented.</p>	<p>i) Two of five residents with a previous history of constipation have no evidence of monitoring of bowel activity documented.</p> <p>ii) Five of five residents following an unwitnessed fall do not have the clinical monitoring required by the organisations falls policy documented.</p>	<p>I-ii) Ensure that all required monitoring is documented.</p> <p>90 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>The activities coordinators complete an activities assessment on admission and document an activity care plan in consultation with the resident or their family. The group activity programme for the month is placed on the residents' noticeboards and the current days programme is documented on a whiteboard in the front entrance.</p> <p>Four of four activity care plans due for review have not been reviewed six-monthly or reviewed at the same time the long-term care plans are reviewed, or against the resident's stated goals.</p>	<p>Three of four activity care plans due for review, have not been reviewed in the required timeframes, or reviewed in conjunction with a review of the long-term care plan or reviewed against the resident's stated goals.</p>	<p>Ensure all activity care plans are reviewed at least six-monthly and are reviewed at the same time as a review of the long-term care plan and reviewed against the resident's stated goals.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes</p>	PA Moderate	<p>Corridors are wide in all areas to allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. The service has</p>	<p>i) The food preparation bench top is made of formica and pieces of formica have broken off leaving exposed wood.</p> <p>ii) The cupboards under the kitchen sink</p>	<p>Ensure that all outstanding maintenance in the kitchen is</p>

safe mobility, aids independence and is appropriate to the needs of the consumer/group.		an implemented preventative maintenance plan. The service has recently replaced the walls behind the cooker with stainless steel. Not all maintenance required in the kitchen had been completed on the day of audit, however, there is a plan in place to complete the outstanding work by June 2017.	have chipped paint on the edges leaving exposed wooden surfaces. ii) The lino is cracked and peeling.	completed.  90 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.	PA Moderate	Staff are provided with training on fire safety and fire evacuation and are required to complete a fire safety competency quiz. The last trial fire evacuation was held in May 2016. The service booked a trial evacuation during the audit and advised this would be completed within the month	A trial fire evacuation has not been held six-monthly. The last trial fire evacuation was in May 2016	Ensure that trial fire evacuations are held at least six-monthly  30 days

## 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.