# Arbor House Trust - Arbor House Rest Home

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Arbor House Trust

**Premises audited:** Arbor House Rest Home

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

**Dates of audit:** Start date: 14 June 2017 End date: 14 June 2017

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 22

# 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** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Arbor House Rest Home is owned and operated by a Community Trust. Arbor House rest home provides rest home and hospital level care across 26 beds. On the day of audit there were 22 residents.

The trust board employs a nurse manager who is responsible for the daily operations of the service. The nurse manager has been in the role since 2014. The nurse manager is supported by registered nursing, administration and care staff. The nurse manager reports to the trust board monthly.

This unannounced surveillance audit was conducted against the Health and Disability Standards and the contract with the District Health Board. The audit process included review of policies and procedures, review of residents and staff files, observations and interviews with residents, family and staff.

Residents and family interviewed spoke positively about the service provided.

Nine of the thirteen previous shortfalls have been addressed around; meeting minutes and corrective actions, performance appraisals, progress notes, weight loss management, self-medicating residents, hot water temperature monitoring, review of infection control programme, restraint job description and assessments.

Improvements continue to be required around completion of accident/incident forms, meeting timeframes, care plan interventions and aspects of medication management.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

Policies are implemented to support residents’ rights, communication and complaints management. Residents and families are kept informed following an adverse event. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

A nurse manager who has been in this role since May 2014 manages the service. She is supported by senior registered nurses and other care staff. Strategic goals provide direction. The quality and risk management programme is established and implemented. Quality activities are conducted, which generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. Residents meetings are held and residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. An education and training programme has been implemented with a current plan in place. Appropriate employment processes are adhered to and employees have an annual staff appraisal completed. There is a roster that reflects sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Initial assessments and risk assessment tools are completed by the registered nurses on admission. Registered nurses are responsible for care plan development with input from residents and family. Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are managed and administered in line with legislation and current regulations. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |

The building has a current warrant of fitness.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

There is a documented definition of restraint and enablers that aligns with the definition in the standards. There were nine residents requiring restraint and no residents with an enabler. Enabler use is voluntary.

## Infection prevention and control

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

There is a defined surveillance programme with monthly reporting by the infection control coordinator.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 17 | 0 | 1 | 3 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 1 | 3 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. Complaint forms are available at reception. The residents interviewed were aware of the complaints process and to whom they should direct complaints. The service had one complaint in 2016 and have had one complaint in 2017 to date. Acknowledgement, investigation, resolution and sign-off of the complaints were completed within the required timeframes. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Rest home residents interviewed (five) stated their relatives are informed of changes in health status and incidents/accidents with their consent. This was confirmed on incident forms reviewed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings have occurred regularly and management have an open-door policy. The residents stated that the nurse manager is on site five days per week and visits each resident to enquire about their wellbeing. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Arbor House rest home provides rest home and hospital level care across 26 beds. There are ten rest home beds, ten hospital beds and six dual-purpose beds. On the day of audit, there were 22 residents (eleven rest home and eleven hospital level). There was one resident on an ACC contract, all other residents were under the ARCC. A nurse manager who has been in this role since May 2014 manages the service. She has a background in emergency nursing and has non-clinical management experience in a district health board. She is supported by a senior registered nurse (identified as being in charge in the absence of the manager) who has been in the role for two years and an office manager who has been in the position for three years. The nurse manager reports monthly to the community trust board.  Arbor House rest home is owned and operated by a Community Trust. This ‘not for profit’ trust is led by a board of directors. There is a documented mission statement and philosophy. The current quality improvement and risk management plans have been implemented with progress toward goals and achievement documented. There is a business plan 2016-2017 with long-term strategies and short-term goals. The goals for 2017 and direction of the service are well documented.  The nurse manager has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital. The nurse manager was on annual leave on the day of audit and was not available. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The service collects incident and accident data and reports aggregated figures monthly to the board, and monthly to the staff and clinical/RN meetings. Staff interviewed confirmed that incidents and accidents were discussed with them. Not all incident forms reviewed identified assessment and follow-up by a registered nurse, this is a continued finding from the previous audit. The registered nurses interviewed stated that on admission the family and/or resident are informed regarding the Arbor House policy to only contact family in the event of serious injury following an accident/incident. Care plans reviewed documented when family wished to be contacted regarding incidents/accidents. Incident forms identified that family were informed of incidents as per their instructions, this is an improvement from the previous audit. The senior registered nurse interviewed was aware of when and who to report essential notification to and could provide examples. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | PA Moderate | The service collects incident and accident data and reports aggregated figures monthly to the board, and monthly to the staff and clinical/RN meetings. Staff interviewed confirmed that incidents and accidents were discussed with them. Not all incident forms reviewed identified assessment and follow-up by a registered nurse, this is a continued finding from the previous audit. The registered nurses interviewed stated that on admission the family and/or resident are informed regarding the Arbor House policy to only contact family in the event of serious injury following an accident/incident. Care plans reviewed documented when family wished to be contacted regarding incidents/accidents. Incident forms identified that family were informed of incidents as per their instructions, this is an improvement from the previous audit. The senior registered nurse interviewed was aware of when and who to report essential notification to and could provide examples. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Six staff files sampled (a registered nurse (RN), the activities coordinator, the cook, a cleaner and two caregivers) show appropriate employment practices and documentation. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. This finding from the previous audit has been addressed. Current annual practising certificates are kept on file.  The orientation package provides information and skills around working with residents with rest home and hospital level care needs and were completed in all staff files sampled.  There is an annual training plan in place and implemented. There is evidence of caregiver and RN attendance at external education sessions provided by the local district health board. One caregiver is completing education on Heke Rongoa medicine though the Māori Health Unit at Wairarapa District Health Board. Education on pressure injury prevention and management was completed in December 2016 with 13 staff attending. Those staff who did not attend were provided with a printout of the education session to read and discuss with an RN. This previous audit finding has been addressed.  Four of seven registered nurses (including nurse manager) have completed interRAI training.  Residents interviewed stated that staff are knowledgeable and skilled. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented rationale for staffing the service. On the day of audit there were 22 residents (11 rest home and 11 hospital). The nurse manager (registered nurse) works full time and along with a senior registered nurse share after hours on call cover to support staff.  There is a registered nurse on duty on each shift. The RN on duty on the morning and afternoon shifts are supported by four caregivers on each shift.  On night duty, there is one registered nurse and one caregiver on duty.  Staff and residents interviewed confirmed that staffing levels are adequate and that management are visible and able to be contacted at any time. The roster evidenced an increase in staffing to meet increased occupancy and resident needs. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Records within resident files were signed; progress notes reviewed recorded time of entry. This previous audit finding has been addressed. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses are responsible for the administration of medications. They have completed annual competencies and have attended annual medication education. Senior caregivers complete a competency assessment for second check of medications. The service uses an electronic medication system. There is documented evidence of medication reconciliation on delivery of medications. The medication round observed on the day of audit was evidenced to be completed as per policy and procedure.  One resident was self-administering medications at the time of audit. All the necessary assessments, consent and review of competency to self-administer medication have been completed. This previous audit finding has been addressed.  Ten medication charts were reviewed. Not all medication charts documented the indication of use for ‘as required’ medications. This previous audit finding has not been addressed.  Standing orders reviewed comply with legislative requirements. This previous audit finding has been addressed.  Not all medication charts reviewed evidenced that medication management has been reviewed three monthly by a GP.  Medication fridge temperatures are monitored. Temperature recordings reviewed are within the recommended range. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | All meals at Arbor House are prepared and cooked on site. There is a four-weekly seasonal menu which had been reviewed and approved by a dietitian. Meals are delivered to the dining area immediately upon serving. A tray service is available upon request. Dietary needs are known with individual likes and dislikes accommodated. Specialist diets are catered for including soft and pureed diets. Cultural and religious food preferences are met. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines.  Supplements and high protein snacks and drinks are provided to residents with identified weight loss. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.  Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Food was stored correctly.  All staff working in the kitchen has completed training in food safety and hygiene and chemical safety. Kitchen waste is managed appropriately. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Not all resident supports and needs were included in the care plans for all residents’ files reviewed. This previous audit finding has not been addressed. Short-term care plans are developed for acute changes in health status. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications.  In the residents’ files reviewed, short-term care plans were commenced with a change in heath condition and linked to the long-term care plan. Long-term care plans were evidenced to be reviewed six monthly.  Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all thirteen wounds identified at time of audit. There was one pressure injury (grade two) on the day of audit and there was evidence of GP, dietitian, DHB wound care nurse specialist and district nurse involvement. However, interventions to address pressure injury management, pain and nutrition were not addressed in the care plan (link to 1.3.5.2)  Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.  Residents are weighed monthly or more frequently if weight is of concern. Interventions around the management of weight loss/gain are documented in one hospital resident file, where the risk of weight loss and malnutrition was an issue. This previous audit finding has been addressed.  Monitoring occurs for observations, neurological observations signs, blood sugar levels, two hourly turning charts, pain and challenging behaviour. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | A recreation officer (RO) works a minimum of 26 hours per fortnight with an RO assistant also working 26 hours per fortnight providing cover Monday to Friday. RO hours are flexible with fluctuations in occupancy. Volunteers and caregivers assist with activities during the weekends. One volunteer runs story telling sessions and another takes housie.  The activities programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes craft, weekly van outings, church services, entertainment, bingo and bowls. One resident goes out to attend stroke club and others attend groups in the local community. There is a resident cat and relatives bring animals in to visit. There is a day care programme run over three days per week with up to six attending on any given day. On the day of audit residents were observed participating in a variety of activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities.  The RO is responsible for the resident’s individual activity care plans which are developed within the first three weeks of admission. The resident/family/whānau, as appropriate are involved in the development of the activity plan. Resident files reviewed identified that the individual activity plan is completed and reviewed 6 monthly and evidenced outcomes achieved against goals set.  Activities are planned that are appropriate to the functional capabilities of residents and are mostly driven by resident requests. Residents provide feedback individually and make suggestions for activities at the resident meetings and via annual resident satisfaction survey.  Residents and families interviewed report satisfaction with the activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans have been evaluated against the resident goals at least six monthly or earlier for any health changes. There is at least a three-monthly medical review by the GP. However, a review of medication was not evidenced to be consistently completed at time of medical review (link to 1.3.12.1). Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location (expiry 30 June 2017). Hot water temperatures are monitored monthly and are within acceptable range. This is an improvement since previous audit. |
| Standard 3.1: Infection control management  There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service. | FA | The RN is the infection control coordinator supported by an infection control representative (housekeeper) to oversee infection control for the facility. The infection control coordinator has a defined job description that outlines the responsibility of the role. Infection events are collated monthly and reported to the combined staff/quality meetings and board meetings. The infection control programme was reviewed in 2016. This previous audit finding has been addressed. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (registered nurse) collates information obtained through surveillance to determine infection control activities and education needs in the facility. An infection control register is maintained and short-term care plans are completed for infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place, appropriate to the complexity of service provided. Infection control data is discussed at both the staff/quality meetings. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There have been no outbreaks since previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Arbor House has policies and procedures on restraint minimisation and safe practice. A registered nurse is the restraint coordinator. There is a documented definition of restraint and enablers, which are congruent with the definition in NZS 8134.0. There is a restraint and enabler register. There were no residents requiring the use of an enabler and nine hospital residents with restraints in use on the day of audit. One resident required the use of two restraints a bed rail and lap belt, all other restraints in use were bed rails. |
| Standard 2.2.1: Restraint approval and processes  Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others. | FA | The restraint coordinator is a RN and understands the role and her accountabilities. There is a job description in place for the restraint coordinator. This previous audit finding has been addressed. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | A review of restraint documentation for nine residents requiring the use of restraint evidenced that an assessment was completed prior to restraint being implemented. The risks associated around the use of restraint were documented in the resident care plans (nine) reviewed. These previous audit findings have been addressed. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | The service collects incident and accident data and reports aggregated figures monthly to the board and monthly to the staff and quality/RN meetings. Eight of eleven incident forms included RN follow-up. | Of the eleven resident-related incident forms and progress notes reviewed three incidents did not have documented RN assessment following a fall. | Ensure that RN assessment following an incident is documented.  60 days |
| Criterion 1.3.12.6  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. | PA Moderate | An electronic medication system has been implemented. Seven of ten medication charts reviewed included indicators for “as required” medications. Seven of ten medication charts documented three monthly GP review. | (i) Three out of ten medication charts did not document evidence of GP three monthly reviews  (ii) Three of ten medication charts reviewed did not document the indication for use of ‘as required’ medications. | (i) Ensure that medication charts are reviewed by a GP three monthly  (ii) Ensure medication charts document the indication for use of prescribed ‘as required’ medications.  60 days |
| Criterion 1.3.3.3  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. | PA Low | Registered nurses are responsible for the initial admission assessment and care plan, risk assessments including interRAI and development of long-term care plans. Four of six registered nurses are interRAI trained. All (three hospital and two rest home) resident files reviewed identified an initial assessment was completed within 24 hours of admission. InterRAI assessments were not always completed within three weeks of admission. Long-term care plans were not documented for two hospital resident files reviewed. There is evidence of resident and family involvement in care planning. Residents and families interviewed were happy with the care provided.  Advised that during May and June the service took on 6 new residents that were transferred from another facility which was closing. Due to an increase in resident numbers by 25%, staff were pushed to meet timeframes. | i) Two of three hospital files reviewed did not have a long-term care plan completed (both residents had been residing at the facility for more than 21 days).  (ii) InterRAI assessments were not completed within 21 days of admission in four of five (three hospital and one rest home) resident files reviewed. | Ensure interRAI assessments and long-term care plans are completed within 21 days of admission.  60 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Two of five care plans reviewed documented the required support to meet the resident’s needs. Short-term care plans were evidenced in use for acute changes in resident need. | The long-term care plans did not reflect the interventions to support all residents’ current needs for three residents: (i) A hospital level resident identified with a chronic wound and insulin dependent diabetes had no pain management, no pressure area care prevention and management, no diabetes management or nutrition management documented (link to tracer 1.3.3.3); (ii) A rest home level resident identified with current behavioural issues had no behavioural management plan (link to tracer 1.3.3.3). (iii) A rest home level resident identified with insulin dependent diabetes with no diabetes management plan. | Ensure that care plans reflect the required support or interventions to meet the resident’s needs.  60 days |

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

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

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

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

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End of the report.