

Capital Residential Care Limited - Ocean View Residential Care

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Capital Residential Care Limited

Premises audited: Ocean View Residential Care

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 22 September 2017 End date: 22 September 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: 15

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Ocean View Residential Care provides cares for up to 20 residents requiring rest home level care. On the day of the audit there were 15 residents. The service is overseen by a facility manager, who has been in the position since June 2016. She is supported by a clinical nurse manager who has been in the role for two and a half years.

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

The service has addressed five of eleven findings from the certification audit in relation to, cultural safety, organisational policies, hazard management, admission agreements, and infection control programme review.

There continues to be improvements required around internal audit outcomes, corrective actions, aspects of human resources, education, aspects of care planning and equipment.

This surveillance audit identified further improvements required around, documentation timeframes, medication management, and safe food practices.

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 family are well informed including of changes in residents' health. Open communication between staff, residents and families is promoted, and confirmed to be effective. Complaints and concerns have been managed and a complaints register is maintained. Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a Māori healthcare plan and related policies. There is access to formal interpreting services if required.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The quality and risk management programme includes service philosophy, goals and a quality planner. Quality data is collected. Residents/family meetings have been held and residents and families are surveyed annually. There are health and safety policies documented to manage risk. Incidents and accidents are reported and followed through. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme is documented. There are documented employment processes. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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There is an admission process at Ocean View that includes an admission agreement that fulfils contractual requirements. The clinical nurse manager is responsible for each stage of service provision. The clinical nurse manager assesses and develops the care plan documenting supports, needs, outcomes and goals with the resident and/or family/whānau input. Resident files included specialist and allied health notes. The clinical nurse manager and medication competent caregivers are responsible for administration of medicines and complete annual medication competencies.

An activities officer oversees the activity programme for the rest home. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the resident group. Residents report satisfaction with the activities programme. Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site.

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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There is a current building warrant of fitness displayed at the entrance to the facility. A code of compliance certificate has been issued for an upgrade of the existing fire alarm system in November 2016. Certificates of compliance were sighted in regard to ongoing upgrades to the existing electrical system. Chemicals, soiled linen and equipment are safely stored. Residents reported a timely staff response to call bells.

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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Ocean View has restraint minimisation and safe practice policies and procedures in place. On the day of audit, there was one resident with a restraint and no residents using an enabler.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme, led by an experienced and appropriately trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Aged care specific infection surveillance is undertaken and results reported at handover. Follow-up action is taken as and when required.

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	1	6	0	0
Criteria	0	32	0	2	8	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 policy that describes the management of complaints process. There is a complaint's form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints. There is a complaint's register. Verbal and written complaints are documented. There have been three complaints since the last audit. All complaints reviewed had noted investigations, timeframes, corrective actions when required and resolutions in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and</p>	FA	<p>Staff support the three residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau to Māori residents. There is a current Māori healthcare plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on Tikanga best practice is available and is supported by staff who identify as Māori in the facility. One resident who identified as Māori was interviewed and reported that staff acknowledge and respect their individual cultural needs and values. Two Māori resident files reviewed had their cultural values and beliefs addressed in their care plan. The previous finding has been addressed.</p>

acknowledges their individual and cultural, values and beliefs.		
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Management promote an open-door policy. Information is provided in formats suitable for the resident and their family. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. Communication with family members is recorded on the incident report forms and in the resident daily progress notes. Ten incident forms reviewed identify that family were notified following a resident incident. Seven relatives and one family member interviewed confirmed on interview that the staff and management are approachable and available. Staff were observed communicating effectively with residents. The information pack is available in large print and advised that this can be read to residents.</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>	FA	<p>Ocean View Residential Care (Ocean View) is owned and operated by Capital Residential Care Limited. The service provides rest home care for up to 20 residents. On the day of the audit, there were 15 rest home level care residents. This includes four residents on respite, one resident admitted under an Accident Compensation Corporation (ACC) contract and one resident on a 'younger persons with disabilities' (YPD) contract. All other residents were under the aged residential related care (ARRC) contract.</p> <p>The facility manager reports to the owners of the company weekly on a variety of operational issues. Ocean View has a 2016 – 2018 business plan that includes the home mission statement and philosophy of care. The business plan includes current goals which have been evaluated.</p> <p>The facility manager is an enrolled nurse who maintains an annual practicing certificate. The facility manager has been in the position since June 2016. She is supported by a clinical nurse manager who has been in the role for two and a half years. There is a casual registered nurse (RN) who provides back-up for the clinical nurse manager to cover in times of sickness or emergencies.</p> <p>The facility manager and the clinical nurse manager have completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented,</p>	PA Moderate	<p>The quality and risk management programmes includes an internal audit programme and data collection, analyses and review of adverse events including accidents, incidents, infections, wounds and complaints. There is an internal audit programme, however not all scheduled monitoring has been completed. Corrective actions documented are not always signed as implemented. These shortfalls continue to remain an area for improvement since the previous audit. There are monthly quality meetings, bi-monthly staff meetings and four</p>

<p>and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>monthly resident meetings held.</p> <p>All organisational policies reviewed were documented and meet current best practice, legislative and contractual requirements. The previous finding has been addressed around a documented policy for informed consent, death of a resident, safe food handling, interRAI requirements and the policy for challenging behaviour to comply with current best practice. Residents are surveyed annually to gather feedback on the service provided. The 2016 resident survey indicated satisfaction with the service, the 2017 resident survey had not been completed at the time of the audit.</p> <p>There is a health and safety and risk management system in place including policies to guide practice. There is a current hazard register, which was last reviewed in September 2016. Hazards are documented on the register and have interventions documented to manage the risk. There is currently one electric blanket being used by resident, this was identified on the hazard register. The previous finding has been addressed around hazard management. Falls prevention strategies are in place, which include the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical nurse manager investigates accidents, and completes a table of incidents, analysis of the data is not completed (link 1.2.3.6). There is a discussion of incidents/accidents at quality and staff meetings. The clinical nurse manager conducts clinical follow-up of residents. Ten incident forms reviewed demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Three section 31 notifications were completed since the last audit. The notifications were for a pressure injury in February 2017, coroner's inquest in July 2017 and a vomiting/diarrhoea outbreak in September 2017, public health was also informed of the outbreak.</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</p>	<p>PA Moderate</p>	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. Five staff files were reviewed (one facility manager, one clinical nurse manager, two caregivers and one cook). However, signed job descriptions, orientation checklists, up-to-date annual performance appraisal and reference checks were not all evident in all the staff files reviewed. A copy of practising certificates is kept.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The service has an annual education planner that has scheduled education to cover the requirements of the ARRC contract. Not all mandatory topics outlined on the schedule have been delivered in the past two years. The facility manager and clinical nurse manager are able to attend external training,</p>

legislation.		including sessions provided by the local DHB. The clinical nurse manager and facility manager have completed interRAI training.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	Ocean View has a policy for staff rationale. A facility manager and clinical nurse manager are rostered on from Monday to Friday. The facility manager and clinical nurse manager cover the on-call and provide cover for each other for periods of leave. A casual RN provides back up for the clinical nurse manager to cover in times of sickness or emergencies. There are two caregivers on the morning and afternoon shifts, and there is one caregiver on the night shift. There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Residents and relative interviewed confirm that there are sufficient staff on-site at all times and staff are approachable and in their opinion, competent, professional, respectful and friendly.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information on the care services is provided for families and residents prior to or on admission. Six admission agreements for long-term residents were signed. A previous corrective action request to ensure the admission agreement is in line with contractual requirements has been addressed, in respect to specific timeframes around reimbursement of overpayments and not charging for services that are not required to be provided. Exclusions from the service are included in the admission agreement.
<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>	PA Moderate	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses an electronic medication management system for administering medications, however the facility's GP is the only GP at the local practice who is familiar with this system. As evident during audit, when the GP is on leave, locum GPs prescribe manually on a prescription. The pharmacy fills the prescription and provides the facility with a signing sheet. The facility has no documentation with a GPs signature on which to administer the medication.</p> <p>The clinical nurse manager, facility manager and caregivers who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Standing orders are not used. There was one resident who was self-medicating on the day of audit. Compliance with the policy on safe self-administration is not sighted. All medications are stored appropriately.</p> <p>There were no controlled drugs on-site at the time of audit, however safe storage and accuracy of controlled drug records was sighted. All eye drops are replaced each month. The medication requiring refrigeration is</p>

		<p>kept in a container in a fridge in the kitchen, however the temperature of this fridge has not been monitored in the last month. The refrigerated medication in storage was disposed of at audit. All ten electronic medication charts reviewed met legislative prescribing requirements. The GP has reviewed the medication charts three monthly.</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>PA Low</p>	<p>All meals at Ocean View are prepared and cooked on-site by a qualified cook. All staff have attended food safety and hygiene training. The kitchen is clean and tidy and has an "A" grade environmental health grading certificate, issued by the council March 2017. A food control plan has been registered with the council in July 2017, however evidence suggests it has not been implemented, and this requires attention.</p> <p>There is a menu in place. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods are also provided by the service. Special diets include gluten free, vegetarian and low fat/low salt. Staff were observed assisting residents with their meals and drinks in the rest home dining room. Resident meeting minutes along with direct input from residents, provide resident feedback on the meals and food services. Residents and family members interviewed were satisfied with the food.</p> <p>Stores in the pantry are minimal, and reordering is three days away. The cook verifies there will be enough food for the next three days. Good supplies of meat, vegetables, bread, eggs and milk are sighted. Food is allocated and catered for as per the menu.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>There are interventions sighted around the required management of resident diverse needs, including specific medical needs. When a resident's condition alters, the clinical nurse manager initiates a review and if required, a GP consultation. There is evidence that family members were notified of any changes to their relative's health including, accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented in the resident file. A previous corrective action request around residents with high risk of falling having minimal falls prevention management documented in the care plan has been addressed, and sensor mats are available and in use. Managing residents with behaviours that challenge was not clearly documented.</p> <p>The respite resident had a short-term care plan in place that was reflective of current needs.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds and skin tears. There were no pressure injuries on the day of audit. There was a range of equipment readily available to minimise pressure injury.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel</p>

		management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Short-term care plans document appropriate interventions to manage short-term changes in health.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service has a recreation officer who plans and implements the activities programme at the rest home. The activity plan is provided on a Monday to Friday between 09:30 and 15:30. An activity assessment and plan is completed on admission in consultation with the resident/family and reviewed six monthly or as residents needs change. The activity plan in place is in line with the interests of the residents who are participating. There is a variety of activities within the facility available to residents if required. Interviews with six residents revealed four residents preferred to stay in their rooms and not be involved in the activities programme.</p> <p>One of those residents stated, "more community involvement would be nice". A phone interview with the activity officer identified over the winter a lot of outings were cancelled due to weather and the absence of a budget for activities limited the resources available to meet resident's needs. A facility van is available for outings however getting in and out of the van is a problem for some residents. Residents are encouraged to maintain links with the community, and residents often go out with families or down to the local shop. Residents and families have the opportunity at residents' meetings to feedback on the activity programme. Meeting minutes verifies satisfaction.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans reviewed were evaluated by the CNM within three weeks of admission. Long-term lifestyle plans, with the exception of those mentioned (link 1.3.3.3) have been reviewed at least six-monthly or earlier for any health changes. The written evaluation documents the residents' progress against identified goals. The GP reviews the residents every three months (link 1.3.3.3). Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Changes are made to care plans.</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</p>	PA Moderate	<p>Ocean View has a current building warrant of fitness which expires on 2 June 2018. The fire protection system was upgraded in November 2016 and a code of compliance was sighted. The replacement of three fire extinguishers has not been attended to. Ongoing electrical upgrades have been attended to and electrical certificates of compliance for this work has been sighted. A previous corrective action around the electric chair between two floors remains in place. There is a maintenance person, who is called in to do things as needed. Up to date testing and tagging was occurring and hot water temperatures were being monitored</p>

purpose.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme that is documented. A previous corrective action requiring the IPC to be reviewed annually has been addressed, and was reviewed October 2016.</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>Infection surveillance is an integral part of the infection control programme and is described in Ocean View's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance is appropriate to that recommended for long-term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. When an infection is identified, a record of this and management is documented in the residents' clinical records and on infection reporting form. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. The IPC nurse reviews all reported infections.</p> <p>A gastrointestinal outbreak occurring three days prior to and on the day of audit, was managed appropriately. The ministry of health, DHB and public health were notified. Appropriate processes were implemented and in place.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, the service had one resident using a restraint (lap belt) due to risk of seizures. This was well documented in the care plan. There were no residents using an enabler.</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	The organisation has a quality management system in place that schedules the audits and monitoring required. Not all scheduled monitoring of audits had been completed. Data collected for quality and risk management purposes is not always analysed with results communicated to staff. Data is not consistently analysed to identify areas for improvements. This continues to remain an area for improvement.	(i) Eight out of 28 internal audits reviewed had not been completed as per the schedule. ii) Data collected for quality and risk management purposes is not always analysed with results communicated to staff.	i) Ensure that all scheduled audits and monitoring is completed. ii) Ensure that data collected is analysed and shared with staff. 60 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the	PA Moderate	Where audit and monitoring results are less than the expected standard, corrective action plans (CAPs) are developed for areas requiring improvement. The facility manager advised that once a corrective action plan has been implemented the corrective action plan is reviewed and then signed off as	Eight out of the thirteen internal audits that required corrective action plans had not been reviewed or signed off as completed.	Ensure that all corrective action plans are reviewed and signed off once completed.

specified Standard or requirements is developed and implemented.		completed by the facility manager. Not all corrective action plans sighted had been reviewed or signed off by the facility manager and this remains an area for improvement.		60 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. However, signed job descriptions, and up-to-date annual performance appraisal continue to not be available in all five staff files reviewed and this remains an area for improvement.	Ensure that all staff files have a signed job description and an up-to-date annual performance appraisal on file.	Ensure that all staff files have a signed job description and an up-to-date annual performance appraisal on file. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The service has an annual education planner that has scheduled education to cover the requirements of the ARRC contract. Since the previous audit advocacy and cultural awareness has been provided, however not all mandatory topics outlined on the schedule have been delivered in the past two years. This finding remains open and an area for improvement.	i) Education has not been provided in the past two years for the following mandatory training, care planning, nutrition/hydration, end of life, communication, skin integrity/pressure area, abuse/neglect, spirituality/counselling, sexuality/intimacy, wound care and the aging process. ii) Where staff attendance numbers have been low at mandatory education sessions provided, no follow-up education or training has been provided.	i) Ensure that the education schedule is fully implemented and education is provided to cover all contractual and legal requirements. ii) Ensure that a process is put in place to ensure that all staff attend mandatory education and where attendance is low an education follow-up plan is implemented. 60 days
Criterion 1.3.12.1	PA	The facility uses an electronic medication system to	(i)Twelve electronic medication	(i)Ensure medication is

<p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>Moderate</p>	<p>administer medications, however when the GP is away the other GPs do not know how to use it, and resort to a manual system.</p> <p>The prescription goes to the pharmacy, the pharmacy fills the prescription and provides the facility with a pharmacy generated signing sheet, from which the facility administers the medication. There is no signed authorisation by the GP to guide administration by the staff of Ocean View.</p> <p>In addition, residents requiring a change in their warfarin dose by INR result, do not have this updated electronically when the GP is away. The facility administers the change in dose, based on the lab result faxed to them.</p> <p>Interviews with the CNM and FM, states the GP says the other GPs have been trained, but the electronic system continues to not be used when the GP is on leave.</p>	<p>charts reviewed. Two had not been updated and included pharmacy generated signing sheets. The pharmacy generated signing sheets were followed by staff, there was no signed authorisation by the GP to guide administration by the staff of Ocean View. (ii)One of two warfarin charts had not been updated electronically and staff were administering based on the lab result faxed.</p>	<p>administered from GP signed medication charts either electronically or hard-copy; (ii) Ensure the required warfarin dosage for administration is signed by the GP.</p> <p>30 days</p>
<p>Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>The medication management policy describes procedures around self-medicating, however one resident self-medicating had no documentation to reflect resident competency to self-administer has been assessed.</p>	<p>A resident who is self-administering medication has no documentation to verify resident's competency</p>	<p>Ensure residents self-medicating are regularly assessed as competent to self-administer and that this is documented</p> <p>30 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation,</p>	<p>PA Low</p>	<p>A food control plan has been registered with the council in July 2017, however the following evidence demonstrates it has not been implemented. Fridge and freezer temperatures are monitored in the kitchen, however there is no evidence of monitoring within the past month. Cooked meat temperatures are monitored daily. A kitchen cleaning schedule is</p>	<p>(i)There is no documented evidence that fridge and freezer temperatures have been monitored the last month; (ii) while the kitchen was visually sited as clean, the cleaning checklist had not been signed</p>	<p>Provide evidence safe food handling practices are consistently maintained in the kitchen.</p> <p>60 days</p>

<p>delivery, and disposal comply with current legislation, and guidelines.</p>		<p>in place, however there is no verification of compliance.</p> <p>A build-up of ice and food in the freezer is indicative of it needing defrosting and the cook is unable to say when this last occurred. A number of dry food items are noted to be past their use by date and some items in the fridge have not been dated.</p>	<p>as completed. (ii) Ensure all food in the fridge is dated and expired food removed. Since the audit the service has provided evidence that cleaning schedules and monitoring are now being documented as completed and monitored.</p>	
<p>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.</p>	<p>PA Moderate</p>	<p>Resident files sampled identified that there was no consistent documentation verifying the GP had seen the resident within 48 hours of admission, monthly or three-monthly. There was no verification the resident was stable and able to be reviewed three monthly. The RN interviewed verified the residents were seen within 48 hours of admission and three-monthly GP reviews were completed. A schedule is sighted that records when visits are made and due. Resident interviews verify frequent GP visits, with no hesitation if they are unwell. The clinical nurse manager was unaware of the contractual requirement for monthly visits, unless the resident is deemed stable by the GP.</p> <p>Interviews with the clinical nurse manager and the facility manager both make reference that the GP frequently is unable to visit the rest home and residents are taken to the medical centre, often having to wait a long time to be seen. The nurse accompanying the resident is given verbal advice for management of the resident, but clinical records from the GP are often not forthcoming despite ongoing requests.</p> <p>InterRAI assessments were sighted in the files reviewed of ARRC residents, however, not all interRAI assessments had not been reviewed at least 6 monthly. Three of the five long-term files</p>	<p>(i) In five long-term resident files reviewed identified that there was no consistent documentation verifying the GP had seen the resident within 48 hours of admission, monthly or three-monthly</p> <p>(ii) In four ARCC resident files reviewed, there was no documentation to verify that the resident was stable and able to be reviewed three monthly.</p> <p>(iii) Two of the five long-term resident files reviewed had no long-term care plan (LTCP) in place within three weeks of admission or at the time of audit.</p> <p>(iv) Two of four ARCC residents reviewed had previous interRAI assessments which had not been reviewed within the previous twelve months</p>	<p>(i) Ensure resident files reflect GP records on admission and monthly on three monthly; (ii) Ensure GP records identify that whether the resident is to be seen monthly or three monthly; (iii) Ensure long-term residents have a LTCP in place within three weeks; (iv) Ensure ARCC residents have an interRAI assessment reviewed at least 6 monthly or when needs change.</p> <p>60 days</p>

		<p>reviewed had long-term care plans in place within three weeks of admission. Interviews with the clinical nurse manager confirmed one was in the process of being completed, whilst care for the other resident was being guided by the care plan from a previous placement until it could be completed. Both residents had been admitted over three months prior.</p>		
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Overall the five long-term resident files reviewed identified that interventions to manage residents' current needs was comprehensive. Two of six residents identified high risk of falls-with interventions in place to minimise. Falls management were well documented for at risk residents and this is an improvement on previous audit. However, two residents who display episodes of challenging behaviour and have a monitoring form in place to monitor the frequency of these episodes, had no behaviour management plan in place to guide staff on how to best manage these events.</p>	<p>Two residents with episodes of challenging behaviour have no behaviour management plan documented.</p>	<p>Ensure residents with behaviours that challenge have plans in place to guide staff in managing that behaviour.</p> <p>60 days</p>
<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>A previous requirement for an electric chair operating between the two floors remains in place. The requirement was for it to be tested yearly, it has been tested in April 2016, and meets the standards, however has not been tested since. The electric chair is not being used at this time. An inspection of fire equipment in March 2017, identified three fire extinguishers that need replacing and cannot be guaranteed to operate as required if not replaced. These have not at this stage been replaced.</p>	<p>The electric chair requires regular testing as per manufacturers specifications and three fire extinguishers require replacing. Since the draft report the service has provided documented evidence that the electric chair was serviced 3/10/17 and the three fire extinguishers replaced 9 October 2017</p>	<p>Provide evidence that the electric chair meets safety guidelines and fire extinguishers have been replaced.</p> <p>30 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.