# Kyber Health Care Limited - Waikiwi Garden 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:** Kyber Health Care Limited

**Premises audited:** Waikiwi Gardens Rest Home

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

**Dates of audit:** Start date: 28 September 2017 End date: 28 September 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:** 39

# 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 |
|  | 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

Waikiwi Gardens Rest Home is certified to provide rest home level care for up to 42 residents. On the day of the audit there were 39 residents.

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 facility is managed by two owner/directors (husband and wife) who have the responsibility of the daily operations, finance, maintenance and overseeing the delivery of services. The owner/directors have owned the rest home since March 2017. They are supported by two full-time registered nurses who are responsible for overseeing the clinical service and an assistant manager.

The service has addressed seven of the ten findings from the previous provisional audit regarding; scheduled meetings, training, registered nurse documentation, contractual timeframes, care plan evaluations, kitchen cleanliness and infection control programme.

There continues to be improvements required around implementation of care, medication documentation, and environmental hazards.

This surveillance audit identified improvements required around health and safety, orientation programme, activity plans, and self-medicating.

## 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. |

Information about services provided is readily available to residents and families/whānau. Residents and family are well informed including of changes in resident’s health. The owner/directors have an open-door policy. Complaints processes are implemented and managed in line with the Code of Health and Disability Services Consumers’ Rights.

## Organisational management

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

Waikiwi Gardens Rest Home has a documented quality and risk management system that supports the provision of clinical care. Policies and procedures are maintained by an external quality advisor who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints and internal audits surveys. There are human resources policies including recruitment, job descriptions, selection and orientation. There is an annual education/training schedule in place. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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. |

The registered nurses are responsible for each stage of service provision. A registered nurse assesses and develops the care plan documenting supports, needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were reviewed at least six-monthly. Resident files included the general practitioner, specialist and allied health notes. Medication policies reflect legislative requirements and guidelines. Staff that are responsible for administration of medicines, complete annual education and medication competencies. The medicine charts reviewed were reviewed at least three-monthly.

One recently appointed diversional therapist is recreating the activity programme for the residents. The programme runs during the day Monday to Friday. The programme includes community visitors and outings, entertainment and activities. All meals and baking are done on-site. Residents' food preferences, dietary and cultural requirements are identified at admission and in an ongoing manner and accommodated. 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

|  |  |  |
| --- | --- | --- |
| 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. |

The building holds a current warrant of fitness.

## 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. |

There are policies around restraints and enablers. On the day of the audit there were no residents using restraints and one resident using an enabler. Staff receive mandatory training around restraint minimisation.

## 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

## 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 | 10 | 0 | 4 | 2 | 0 | 0 |
| **Criteria** | 0 | 34 | 0 | 5 | 2 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

|  |  |  |
| --- | --- | --- |
| **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 | There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The manager leads the investigation of any concerns/complaints in consultation with the registered nurses (RN) for clinical concerns/complaints. Complaint forms are visible throughout the facility. A complaints procedure is provided to residents within the information pack at entry. A complaints register is maintained. There has been one complaint made since the last audit. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainant. Corrective actions were implemented and followed up.  Residents and families interviewed are aware of the complaints process. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. Information is provided in formats suitable for the resident and their family. Five residents and four relatives interviewed confirmed that the staff and management are approachable and available. Fourteen incident forms reviewed identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any incidents/accidents. Families are invited to attend the monthly resident/family meetings. Interpreter services are available as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Waikiwi Gardens Rest Home provides care for up to 42 rest home level residents. On the day of audit there were 39 residents, including three residents on a ‘younger persons’ with disabilities’ (YPD) contract. All other residents are under the aged related residential care (ARRC) agreement. There were five independent boarders living within the rest home who are independent and do not receive care services.  The facility is managed by two owner/directors (husband and wife) who have the responsibility of the daily operations, finance, maintenance and overseeing the delivery of services. The manager (wife) looks after the operational/staff management and the co-manager (husband) covers the maintenance/property requirements. The owner/directors (both non-clinical) have owned the rest home since March 2017 and they are supported by two full-time RNs who are responsible for overseeing the clinical service. Both RNs have a current annual practicing certificate. They are also supported by a non-clinical assistant manager who coordinates and oversees quality activities and human resources. |
| 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. | PA Low | Waikiwi Gardens Rest Home has a quality and risk programme that is being implemented around service delivery and staff management. Policies and procedures are maintained by a recognised aged care consultant, who reviews policies to ensure they align with current good practice and meet legislative requirements. Staff confirmed they are made aware of any new/reviewed policies. There are monthly staff and fortnightly management meetings scheduled which commenced in March 2017. Staff and management meetings are completed as per the scheduled calendar. The previous finding has been addressed around scheduled staff and management meetings. The meeting minutes identified that quality data as being discussed including infections, accidents and incidents, concerns/complaints and internal audits. Staff are required to read and sign the quality data information which is generated monthly.  There is a 2017 internal audit programme that covers all aspects of the service including environmental, food service, cleaning service, resident care and documentation. Corrective actions for partial compliance had been developed, implemented and signed off by the assistant manager. A resident satisfaction survey is completed annually. Resident meetings are monthly and provide residents with a forum for feedback on the services. The manager and assistant manager facilitate the resident meetings.  The manager is the health and safety officer. Staff complete hazard identification forms for identified/potential hazards. There is a current hazard register. There are currently no staff members that have completed the specific health and safety training required. Health and safety has not been discussed at the staff and management meetings since March 2017. There is a falls prevention and management policy in place and falls are addressed on an individual basis as part of the care planning process. A 24-hour clock is completed each month to analyse time and location of falls and other incidents such as challenging behaviours. Corrective actions are identified and implemented where appropriate. |
| 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. | FA | There is an incident reporting policy that includes definitions and outlines responsibilities. Fourteen accident/incident forms for the month of August 2017 were reviewed. All document timely RN review and follow-up. There is documented evidence the family had been notified of incidents/accidents. Discussions with the owner/directors confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There has been one section 31 notification lodged since the last audit regarding a fire in a resident’s room in March 2017, the fire was contained to the resident’s room. |
| 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. | PA Low | There are human resources policies to support recruitment practices. Five staff files (one RN, two caregivers, two cooks and one assistant manager) were reviewed. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. Six of six staff files reviewed did not have an orientation checklist included. Performance appraisals were current. Current practising certificates were sighted for the RNs. The two RNs have completed interRAI training. All staff have a current first aid certificate.  The service has an orientation programme in place to provide new staff with relevant information for safe work practice, however this is not being fully implemented. The RNs and caregivers’ complete competencies relevant to their role such as medications. There is an education planner in place that covers compulsory education requirements over a two-year period. The two cooks have attended food safety training (sighted) and all clinical staff attended pressure injury prevention education on 7 March 2017. This previous finding has been addressed. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are always two care staff on duty 24 hours a day, seven days a week. The owner/directors work full time from Monday to Friday and are readily available to staff 24/7. There are two full-time RNs who work from Monday to Friday, one covers from 8.00am to 4.00pm and the other from 9.00am to 5.00pm. The RNs share the on-call duties. They are supported by two caregivers on the morning and on the afternoon shifts, and two caregivers on the night shift. Caregivers interviewed confirmed the RNs are readily available after hours. The residents interviewed inform there are sufficient staff on duty at all times. The rosters sighted confirmed that staff are replaced on the roster. |
| 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. There is an electronic system in place. Staff who administer medications have been assessed for competency on an annual basis. Medications received (blister packs) are checked on delivery by both RNs. All medications are stored safely. All eye drops are dated on opening. The medication fridge is monitored weekly.  Nine of ten medication charts reviewed met legislative prescribing requirements. The GP has reviewed the medication charts three-monthly. Administration records demonstrated that all medications (including non-packed) are signed as administered (e.g., Ural sachets). One medication that was not currently charted (oxygen) was being administered as per discharge note from hospital. Medication errors were documented on incident forms and investigated with competencies of staff being reviewed where appropriate. The internal auditing programme includes medication audits completed by RNs. ‘As required’ medications had documented reason for administration.  Policies for controlled medications document a safe practice that includes two medication competent staff signing for medications, one being a RN when a RN is on duty. There are controlled drugs in use and have been checked and signed by two medicine competent staff, one of which is the RN when on duty. There was one self-medicating resident on the day of the audit. There was no documented competency for this resident. |
| 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 Waikiwi Gardens Rest Home are prepared and cooked on-site by a qualified chef and cook. There is a four-weekly seasonal menu, which had been reviewed by a dietitian in February 2014. Food preferences are met and staff can access the kitchen at any time to prepare a snack if a resident is hungry. The cook receives a dietary profile of resident dietary requirements and any likes or dislikes including updates. Special diets including modified foods are provided although only diabetic diets were required at the time of the audit. Management are considering dietitian input.  Staff were observed assisting residents with their meals and drinks in the main dining room. Fridge, freezer and end-cooked temperatures are monitored weekly. A kitchen cleaning schedule is being implemented and cleaning is now of an acceptable standard. The previous finding has been addressed. Chemicals are stored safely within the kitchen. Resident meetings 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 and confirmed alternative food choices were offered for dislikes. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident's condition alters, the RN initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families were documented in the resident’s progress notes. Adequate dressing supplies were sighted in the treatment room. Wound management policies and procedures are in place. Initial wound assessments and ongoing evaluations were in place for two residents with skin tears. There was a range of equipment readily available to minimise pressure injury. There is access to a wound nurse specialist at the DHB as required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.  Short-term care plans document appropriate interventions to manage short-term changes in health such as infections, however, in one file reviewed, had no fluid balance chart commenced when intervention recommended increasing fluid intake. Monitoring forms are used, for example, observations, behaviour, blood sugar levels and neurological signs. Care plans documented resident’s current needs. The facility has recently purchased sitting scales and a standing hoist. The previous finding has been addressed around provision of weigh scales appropriately according to resident need and identifying weight loss in residents, however, an improvement has been identified around the implementation of care. |
| 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. | PA Low | There is one recently appointed diversional therapist, who has been in the role three months. She works 30 hours per week and provides an activities programme over five days from 9.00am to 3.00pm Monday to Friday. There were no up to date activities plans in four out of five files. The diversional therapist noted this in commencement of employment and is working through this at present. Activities take place in the main lounge and a large plan is available. The programme is varied and interesting with board games, quizzes, reading, bowls, and exercises.  Links with the community involve visiting kindergartens, visiting community choirs, music entertainers and church services. A social history and activity plan is to be completed on admission in consultation with the resident/family (as appropriate). The diversional therapist is working her way through files, reviewing and updating activities preferences as required. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | All initial care plans reviewed were evaluated by an RN within three weeks of admission. In all files sampled the long-term care plans have been reviewed at least six monthly or earlier for any health changes. There has been a new form created and implemented to measure achievement against goals achieved at six-month intervals. The previous finding has been addressed. The GP reviews the residents at least three-monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Files reviewed demonstrated that short-term needs were documented on short-term care plans, which were regularly evaluated. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Moderate | The facility has a current building warrant of fitness that expires 1 February 2018.  There is a reactive and preventative maintenance programme. There are handrails in hallways and bathrooms. The facility has corridors with sufficient space for residents to safely mobilise using mobility aids. The building is two levels. The upstairs level is reserved for residents who are able to manage the stairs independently (currently five of the seven rooms upstairs are occupied by independent boarders). Rippled carpet in two corridors continues to be a trip hazard. Since the previous audit the management team have had the carpet stretched, however this continues to remain an area for improvement. |
| 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. Definitions of infections are in place appropriate to the complexity of service provided. The infection control coordinator collates information obtained through surveillance of all infections (not just those infections that receive antibiotics) to determine infection control activities and education needs in the facility. This previous finding has now been closed out. Individual infection reports and short-term care plans are completed for all infections. A monthly surveillance report includes number of infections by type, trends identified and any corrective actions required.  Infection control data and relevant information is displayed for staff. Infection control data is discussed at staff meetings. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and review the use of antibiotics. There have been no outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. On the day of the audit there were no residents using restraints and one resident was using an enabler (bed rail). Interview with the resident and documentation demonstrated that enabler use is voluntary. Staff receive mandatory training around restraint minimisation and challenging behaviour. |

# 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 1.2.3.9  Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented. | PA Low | The manager is the health and safety officer. Staff complete hazard identification forms for identified/potential hazards. There is a current hazard register. There are currently no staff members that have completed the specific health and safety training required. Health & Safety has not been included for discussion in meetings. | (i) There was no documented evidence of any staff member having completed the specific health and safety training required. (ii) Health and safety has not been discussed at the staff and management meetings since March 2017. | (i)Ensure that a staff member completes the specific health and safety training required. (ii) Ensure that health and safety is a topic at the staff and management meetings  90 days |
| Criterion 1.2.7.4  New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | There are human resources policies to support recruitment practices. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and suitability for the role. The service has a documented orientation programme however this is not being implemented for new staff. Three out of six staff that were new and had started after the new owners purchased the facility in March 2017 did not have a completed orientation checklist on file. | The service has a documented orientation programme, however this is not being fully implemented. Three out of six staff that were new and had started after the new owners purchased the facility in March 2017 did not have a completed orientation checklist on file included | Ensure that the orientation programme is being implemented and this is documented and saved on staff files.  90 days |
| Criterion 1.3.12.1  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. | PA Moderate | Ten medication records reviewed demonstrated that general practitioners prescribe and review medications regularly. Indications for use for ‘as required’ medications were documented and this aspect of the previous finding has been addressed. The two medication rounds observed demonstrated appropriate practice. However, one chart did not have oxygen prescribed following discharge from hospital. This previous finding remains an area for improvement. | No oxygen has been prescribed following discharge from hospital. | Ensure that oxygen is prescribed following discharge from hospital.  30 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There was one self-medicating resident on the day of the audit. There was no documented competency for this resident. | There is no documented competency for this resident | Ensure all self-medication residents have completed competencies and are reviewed at least three-monthly.  60 days |
| 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. | PA Low | The facility has recently purchased sitting scales and a standing hoist. The previous finding has been addressed around provision of weigh scales appropriately according to resident need and identifying weight loss in residents. Five care plans reviewed identified current cares were documented as identified through the assessment process. However, not all interventions were implemented by staff. | The interventions in a short-term care plan for a resident with a chest infection requested “increase fluid intake”. There was no documented evidence to support that this intervention was implemented. The same resident had no vital signs completed. | i) Ensure there is evidence that interventions are actioned. ii) Ensure that vital signs are recorded when chest infection has been identified.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | Activities assessments and plans had been completed in four out of five files. Regular reviews had not been completed since 2016, however the diversional therapist has identified this and is in the process of renewing all resident social histories, activities assessments, plans and evaluations. Weekly attendance records have been commenced. Residents interviewed enjoyed the activities on offer, they felt there was a good variety, and there has been an overall improvement recently | There were no activities reviews completed since 2016, one of five files did not have an activity plan in place | Ensure all residents have an individualised plan that is reviewed at least 6 monthly  90 days |
| Criterion 1.4.2.4  The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group. | PA Moderate | Rippled carpet in two corridors continues to be a trip hazard. Lawyers are dealing with the previous owner to decide who is responsible for replacing the carpet. There are trip hazard signs in place and this has been logged in the hazard register. The co-manager (maintenance/property) has tried to stretch and staple the carpet as able. | The carpet in two corridors is stretched and rippled and poses a trip hazard. | Ensure the carpet does not pose a risk for residents.  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.

|  |
| --- |
| No data to display |

End of the report.