

CHT Healthcare Trust - Lansdowne Hospital and 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](#).

The specifics of this audit included:

Legal entity:	CHT Healthcare Trust
Premises audited:	Lansdowne Hospital and 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: 25 July 2017 End date: 25 July 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:	94

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

CHT Lansdowne is owned and operated by the CHT Healthcare Trust and cares for up to 95 residents requiring rest home or hospital level care. On the day of the audit, there were 94 residents. The service is overseen by a unit manager who is qualified and experienced for the role, and is supported by an acting clinical coordinator and the area manager. Residents, relatives and the GP interviewed spoke positively about the service provided.

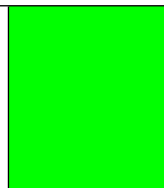
This surveillance audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, staff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

Six of seven shortfalls identified at the previous audit have been addressed. These were around interRAI assessment timeframes and links to care plans, complaint management, staff orientations, evaluations and updating care plans when needs change. Improvement continues to be required around care planning.

This audit has identified additional areas for improvement around incident reporting, wound documentation, one care aspect for one resident, medication management and food storage.

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.

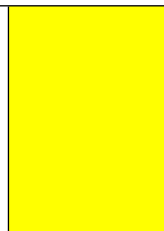


Standards applicable to this service fully attained.

There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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.

CHT Lansdowne (Lansdowne) has a quality and risk management programme that outlines key objectives for the current year. Aspects of quality information are reported at the monthly quality/health and safety meetings. Residents and relatives are provided with the opportunity to feedback on service delivery issues at three monthly resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident accident/incidents. Accident/incidents are collated monthly and reported to facility meetings. Lansdowne has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing and healthcare assistants. Residents and family members report staffing levels are sufficient to meet resident needs.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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A registered nurse completes initial assessments. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Staff have had education around medication management and all staff who administer medications have completed a competency assessment. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

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.		Standards applicable to this service fully attained.
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A current building warrant of fitness is posted in a visible location.

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.

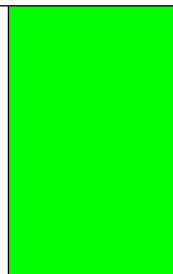


Standards applicable to this service fully attained.

The service has procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with a restraint and two residents using enablers at the time of audit. Staff have received education and training on restraint minimisation and enabler use.

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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. 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	13	0	2	3	0	0
Criteria	0	38	0	3	3	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 the complaints process. The complaints procedure is provided to residents and their family within the information pack at entry. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaint's forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at reception. Complaints received are discussed in the monthly quality/health and safety meetings.</p> <p>There is a complaints register in place. Eleven complaints were made in 2016 and seven complaints received in 2017 year to date. All complaints reviewed have been signed off as resolved. Two complaints made through the Health and Disability Commissioner (HDC) in 2016 were investigated and followed up. The HDC sent letters stating that the complaints were closed off. One complaint made through the local district health board (DHB) in 2016 was investigated and any corrective actions required have been followed up and implemented. A review of the complaints register evidences that the appropriate actions have been taken and the complainant received documented outcome of the complaint. The previous certification audit finding has been addressed.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Seven residents interviewed (four hospital and three rest home) stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>accident/incident and ensure full and frank open disclosure occurs. Fourteen accident/incident forms were reviewed. The accident/incident form includes a section to record family notification. All fourteen accident/incident forms reviewed indicate family are informed. Two families interviewed (hospital level) confirmed they are notified of any changes in their family member's health status. The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Lansdowne is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital level care for up to 95 residents. All beds are dual-purpose beds. On the day of the audit there were 94 residents in total, 19 rest home and 75 hospital level residents. This includes one hospital resident on a younger person with disabilities (YPD) contract and two residents on an interim orthopaedic scheme.</p> <p>The unit manager is a registered nurse (RN) who maintains an annual practicing certificate. She has been in the role for two years and was previously the clinical manager at Lansdowne for eight years. She is supported by a clinical coordinator, who has been in the position since April 2017. Management staff are supported by an area manager. The unit manager reports to the area manager weekly on a variety of operational issues. The unit manager has completed in excess of eight hours of professional development relating to the management of an aged care service in the past twelve months.</p> <p>CHT has an overall business/strategic plan and CHT Lansdowne has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>There is evidence that the quality system continues to be implemented at the service. Interviews with staff and review of the monthly quality/health and safety meetings confirms that quality data is discussed at three monthly quality/health and safety/staff meetings to which all staff are invited. The unit manager advised that she is responsible for providing oversight of the quality programme. Residents and relatives are provided with the opportunity to feedback on service delivery issues at three monthly resident meetings and via satisfaction surveys. Annual resident and relative surveys are completed with results communicated to residents and staff.</p> <p>The service's policies are reviewed at national level with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p>

principles.		
<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>	PA Low	<p>There is an accidents and incidents reporting policy. The unit manager and clinical coordinator investigate accidents and near misses and analysis of incident trends occurs. There is a discussion of accident/incidents at monthly quality/health and safety meetings including actions to minimise recurrence. Fourteen accident/incident forms reviewed documented that clinical follow-up of residents is conducted by a RN. Not all resident accident/incidents had been completed on an accident/incident form. Discussions with the unit manager and area manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no coroners' inquests reported since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resource management policies in place, including the requirement that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files reviewed, one clinical coordinator, two RNs, one activities coordinator and three healthcare assistants (HCAs) evidences that reference checks are completed before employment is offered. Annual staff appraisals and orientation checklists were evident in all seven of the staff files reviewed. The previous certification audit finding has been addressed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2016 has been completed and the 2017 programme is being implemented. Healthcare assistants have completed an aged care education programme. The unit manager and RNs can attend external training including sessions provided by the local DHB. Nine of thirteen RNs are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</p>	FA	<p>CHT policy includes staff rationale and skill mix. Staff are rostered on to manage the care requirements of the residents. The facility consists of three interlinked hospital level units (two 20 bed units and one 15 bed unit) and two rest home units (20 beds per unit). In addition to the unit manager and clinical coordinator who work Monday to Friday, three RNs are rostered on the AM shift and three RNs on the PM shift (two in the 20 bed hospital units and one in the rest home units) and one RN in one of the 20 bed hospital units on the night shift. The RNs hold current</p>

<p>and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>first aid/CPR certification.</p> <p>Adequate numbers of HCAs are rostered with four HCAs rostered on the morning shift, two HCAs on the afternoon shift and one HCA on the night shift in the two 20 bed hospital units.</p> <p>There are three HCAs rostered on the morning shift, two HCAs on the afternoon shift and one HCA on the night shift in the 15 bed hospital unit.</p> <p>There are four HCAs rostered on the morning shift, three HCAs on the afternoon shift and one HCA on the night shift in the two 20 bed rest home units.</p> <p>Extra staff are called on for increased resident requirements. Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice did not comply with the medication management policy for the medication round sighted. Medication prescribed is signed as administered on the pharmacy generated signing chart. Registered nurses and senior health care assistants administer medicines. All staff that administer medication are competent and have received medication management training. The facility uses a robotic pack medication-management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Controlled drugs are stored securely and signed out by two people. However, not all required weekly checks have occurred. Medical practitioners write medication charts correctly and there was evidence of three-monthly reviews by the GP. One resident self-administers medicines but does not have a competency assessment.</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>There is a fully functional kitchen and all food is cooked on-site by contracted kitchen staff. There is a food-services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and is provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed recently by a dietitian. The temperatures of refrigerators, freezers and cooked foods are not always monitored and recorded. There is special equipment available for residents if required. Not all food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All relevant personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Relevant risk assessment tools were completed on admission and risk assessments were reviewed at least six-monthly or when there was a change to a resident's health condition in files sampled. InterRAI assessments are occurring and all residents have been assessed to date. InterRAI initial assessments and assessment summaries were evident in printed format in all files, and were comprehensively completed. This is an improvement since the previous audit. The care plans are developed on the basis of these assessments (link 1.3.5.2).</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Three of six care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. The issue around care plan interventions identified in the previous audit continues to require improvement. Residents and their family/whānau are involved in the care planning and review process. Short-term care plans were in use and were utilised for changes in health status or acute needs and were evaluated on a regular basis and signed-off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialist care professionals. Staff interviewed reported they found the plans easy to follow.</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>Registered nurses (RNs) (including the clinical coordinator) and healthcare assistants follow the care plan (link 1.3.5.2) and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (e.g., to the district nurse). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. Behaviour monitoring occurred and interventions including triggers to manage behaviour were documented in two care plans sampled for residents with behaviours that challenge. Healthcare assistants interviewed could describe the management of behaviours and were observed implementing these.</p> <p>Wound assessments and management plans were not in place for every wound. Monitoring was documented for all wounds including pressure areas. All wounds have been reviewed in appropriate timeframes. The RNs have access to specialist nursing wound care management advice through the district nursing service.</p> <p>Interviews with registered nurses, the clinical coordinator and healthcare assistants demonstrated an understanding of the individualised needs of residents. Food and fluid charts are comprehensively completed as required. However, one resident had not had a blood test as requested by the DHB.</p> <p>Monitoring charts including intentional rounding, food and fluid charts and turning charts demonstrated interventions to meet residents' needs.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>Two activities coordinators are employed (one full time Monday to Friday and one part-time (25 hours – who also covers weekends) to operate the activities programme for all residents over seven days. A separate programme is run in the rest home and the hospital with residents able to choose which programme they would like to attend. Each resident has an individual activities assessment on admission by the registered nurses, with input from the activities staff. An individual activities plan is then developed as part of the care plan. Residents are free to choose whether to participate in the group activities programme or their individual plan and participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to and activities within the community. All long-term resident files sampled have a recent activity plan within the care plan and this is evaluated at least six-monthly when the care plan is evaluated. Residents and families interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurses evaluate all initial care plans within three weeks of admission. There is at least a three-monthly review by the GP. An RN completes care plan reviews and all reviews sampled documented progress toward the goals. This is an improvement since the previous audit. All files evidenced that changes had been initiated to the care plan where progress was different from expected. This is an improvement since the previous audit. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment has been recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</p> <p>A current building warrant of fitness is posted in a visible location, expiry 4 March 2018.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in CHT'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 of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the unit manager.</p>

<p>out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has documented systems in place to ensure that the use of restraint is actively minimised. The clinical coordinator is the designated restraint coordinator. On the day of the audit there were no residents with a restraint and two hospital level residents using enablers. Restraint processes are implemented to assess residents for enabler use, which is voluntary. Staff interviews and staff training records evidence guidance has been given on restraint minimisation and enabler usage. Restraint/enablers are discussed in the monthly quality/health and safety meetings.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>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.</p>	PA Low	There is an accidents and incidents reporting policy. The unit manager and clinical coordinator investigate accidents and near misses and analysis of incident trends occurs. Fourteen accident/incident forms reviewed documented that clinical follow-up of residents is conducted by a RN. Not all resident accident/incidents have been completed on an accident/incident form.	Two accident/incident forms were not completed for bruising incidents that were documented in the resident’s progress notes.	<p>Ensure that accident/incident forms are completed for all residents’ accident/incidents that occur.</p> <p>90 days</p>
Criterion 1.3.12.1	PA	All staff who administer medications have been assessed as	(i) During the observed	(i) Ensure

<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>competent to do so. All prescribed medications have been signed as administered. Medications are stored safely in each medication room (rest home and hospital) and all eye drops in use had been dated when they were opened. The unlocked medication trolley was left unattended in the rest home. Controlled drug weekly checks have occurred in the hospital but not always in the rest home.</p>	<p>medication round the registered nurse left the unlocked medication trolley in the dining room at lunchtime and left the room to get something from the treatment room. (ii) Weekly controlled drug checks have not always occurred in the rest home.</p>	<p>medications are stored safely at all times including during medication rounds. (ii) Ensure weekly controlled drugs checks occur.</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>There is one rest home level resident who self-administers medication. The medications were observed to be stored safely and the resident could describe appropriate management of their medication. No competency assessment had been recorded.</p>	<p>The resident that self-administers medication did not have a competency assessment completed.</p>	<p>Ensure all residents that self-administer medications have a current competency assessment.</p> <p>60 days</p>
<p>Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply</p>	<p>PA Low</p>	<p>The contracted provider of the food service has appropriate policies around food storage including temperature monitoring and labelling and the main cook described these when interviewed. However, they had not been implemented at the time of the audit.</p>	<p>(i) Cool stored and freezer temperatures had not been recorded for the five days prior to the audit. (ii) There was food in the cool store and pantry that was not dated.</p>	<p>(i) Ensure cool store and freezer temperatures are recorded daily as per policy. (ii) Ensure all stored food is dated.</p>

with current legislation, and guidelines.				60 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	<p>Three of six care plans described the support and interventions required to meet the resident's goals.</p>	<p>(i) One rest home resident care plan sampled did not address shortness of breath or the need for an air mattress; (ii) one rest home resident file did not address the falls risk. (iii) One hospital resident care plan sampled did not address aspiration risk or the interventions related to the resident being a diabetic on insulin.</p>	<p>(i)-(iii) Ensure care plans fully document all interventions required.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>Registered nurses have completed training around wound assessment and management, including the management of pressure injuries. Four of twelve minor wounds had adequate assessments documented, as did three of the four current pressure injuries. Not all wounds had a documented management plan but regular reviews were documented in a timely manner.</p> <p>Interviews with staff and residents and a review of resident files indicated that all required interventions for long-term residents had been addressed. The interim orthopaedic scheme contract does not require the service to provide medical services to residents. The resident file sampled for a resident on this contract had documented in the discharge summary that the resident needed a blood test, four weeks after discharge. The resident's regular GP had declined to provide a service to the resident while they were in Lansdowne and a house GP had charted the resident's medications. While it was not specifically the service's responsibility to arrange the blood test under the terms of the contract, the discharging service had not been notified that</p>	<p>(i) Eight of twelve minor wounds did not have a comprehensive assessment. (ii) One of the four current pressure injuries did not have the grade or depth documented. (iii) Three of twelve minor wounds and one of four pressure injuries did not have a documented wound management plan. (iv) The one resident file sampled for a resident on the interim orthopaedic scheme had an instruction for a blood test in the hospital discharge summary. This had not occurred.</p>	<p>(i), (ii) and (iii). Ensure all wounds have a comprehensive assessment and management plan documented. (iv) Ensure all cares/procedures required in discharge summaries occur, either by the service or as arranged by the service by another agency.</p> <p>30 days</p>

		the service would not undertake this and the blood test had not occurred.		
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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.