

# Selwyn Care Limited - Selwyn Oaks

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Selwyn Care Limited
<b>Premises audited:</b>	Selwyn Oaks
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 December 2017    End date: 12 December 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	47

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Selwyn Oaks is a Selwyn Foundation aged care facility located in Auckland. The facility is certified to provide rest home and hospital (geriatric and medical) levels of care for up to 66 residents. On the day of audit there were 47 residents. Eighteen rooms have been decommissioned in the current facility. Plans are in place to move to a new (adjacent) facility in February 2018.

This 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 the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The experienced village manager is responsible for the entire retirement village. The care home is overseen by the care manager who is a registered nurse with aged care experience and has been recently employed.

Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided at Selwyn Oaks.

Three of the six shortfalls identified as part of the previous certification audit have been addressed. These include confidentiality, assessment and interRAI process.

Three previous findings continue around: the documentation of the quality process, care planning and services interventions.

This audit has identified one further area requiring improvement around medication management.

## 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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Regular contact is maintained with families. This includes if a resident is involved in an incident or has a change in their current health. There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

## 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.
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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager and care manager/registered nurse are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is established.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. On-going education and training is in place, which

includes in-service education and competency assessments. Registered nursing cover is provided twenty-four hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents. The residents' files are kept secure.

## 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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Care plans are developed and documented on both paper-based and a software system by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with 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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The service displays a current building 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.
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Staff regularly receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. No residents were using restraints or enablers.

## 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.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## 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)
<b>Standards</b>	0	15	0	1	3	0	0
<b>Criteria</b>	0	39	0	1	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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. Complaints forms are available. Information about complaints is provided on admission. Interviews with seven residents (four hospital level and three rest home level) and relatives confirmed their understanding of the complaints process. Eight staff interviewed (three care partners (caregivers), three registered nurses (RNs), one activities staff, one kitchen staff) were able to describe the process around reporting complaints.</p> <p>A complaints register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting requirements determined by the Health and Disability Commissioner (HDC). There is evidence of lodged complaints being discussed in the RN meetings but not in the combined staff meetings (link 1.2.3.6). All 22 complaints lodged in 2017 (year to date) were documented as resolved with appropriate corrective actions implemented.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident into the system. All ten adverse events reviewed met this requirement. Family members (two hospital level) interviewed confirmed they are notified following a change of health status of their family member.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</p>

<p>provide an environment conducive to effective communication.</p>		
<p><b>Standard 1.2.1: Governance</b></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>Selwyn Oaks is a Selwyn Foundation aged care facility located in Auckland. The facility is certified to provide rest home and hospital (geriatric and medical) levels of care for up to 66 residents.</p> <p>Forty-seven residents were living at the facility during this audit (15 rest home level and 32 hospital level). All residents were on the aged related care contract (ARRC). Eleven beds are identified as dual-purpose.</p> <p>Eighteen rooms have been decommissioned in the current facility. Plans are in place to move to a new (adjacent) facility in February 2018.</p> <p>The organisational strategic plan describes their vision, values and objectives. The annual business plan (2017) for Selwyn Oaks documents goals that are linked to the overall strategic plan. Goals are regularly reviewed by the management team and are signed off when achieved.</p> <p>The village manager is responsible for the entire retirement village. He is supported by a care manager/RN, who is responsible for the day to day operations of the care facility. She has been in her role for one year and has four years of aged care experience in New Zealand. An operations manager/RN provides oversight to the Selwyn care facilities. The village manager and care manager have maintained at least eight hours of professional development activities related to managing an aged care facility.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management system is documented. Discussions with the managers (care manager/RN, village manager and operations manager/RN), the GP and staff reflected their involvement in quality and risk management processes.</p> <p>The service has standard operating procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's standard operating procedures are reviewed at a national level by the clinical governance group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to standard operating procedures included procedures around the implementation of interRAI.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to the RNs as evidenced in meeting minutes, but are not documented in the combined staff meeting minutes. Meeting minutes are held in the staff room but were missing three months of information (June – August). The care home manager reported that she also puts</p>

		<p>graphs in the staff room to keep staff informed, but these were not available during the audit. This previous area identified for improvement remains.</p> <p>Resident meetings are held monthly. Minutes are maintained and reflect resolution of issues raised. This is an improvement from the previous audit.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Risk management, hazard control and emergency policies and procedures are in place.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, and identification and meeting of individual needs.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow up action required.</p> <p>A review of ten incident/accident forms for October and November 2017 identified that forms are fully completed and include follow up by a registered nurse. Neurological observations are completed for any suspected injury to the head.</p> <p>The care manager was able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents and unexpected death. This information is also posted in the village manager's office. No section 31 notifications have been required 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>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (two registered nurses, three care partners) included the recruitment process of reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals.</p> <p>A copy of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is an implemented annual education and training plan that exceeds eight hours annually. Aspects of training are provided during full day training sessions. Incidental training is provided according to identified need and at staff request. There is an attendance register for each training session and an individual staff member record of training.</p> <p>Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses including (but not limited to): medication competencies, restraint</p>

		competencies, controlled drug competencies and insulin competencies.
<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	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The care manager works Monday – Friday.</p> <p>There are five wings with higher staff ratios in the wings with hospital level residents. Two RNs are staffed on the AM shift, one on the PM shift and one on the night shift. Six care partners cover the AM shift, seven cover the PM shift and two cover the night shift. Agency staff are used to cover staff absences when permanent staff or staff from the Selwyn bureau are unavailable. The care manager reports that since the commencement of a new roster in July 2017, more permanent staff work over the weekend and this has reduced the number of agency staff required on weekends and improved the continuity of care to residents.</p> <p>Activities are provided seven days a week.</p> <p>Staff working on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files were appropriate to the service type. Information containing personal resident information is kept confidential and could not be viewed by other residents or members of the public. This is an improvement from the previous audit.</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</p>	PA Moderate	<p>There are comprehensive policies and procedures (standard operating procedures) in place for all aspects of medication management, including self-administration. The services uses a computerised system for all medication. RN's check all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy.</p> <p>Registered nurses are responsible for the administering of medications and have completed annual medication competencies and annual medication education. Care partners who act as a second checker also complete a medication competency. There were no self-medicating residents on the day of audit. The medication fridge</p>

<p>and safe practice guidelines.</p>		<p>has temperatures recorded daily and these are within acceptable ranges. No vaccines are stored on site. The medication room was clean, all medications were in date. However, not all medication was dated on opening, oxygen was not stored appropriately and sharps boxes were stored in the clean medication trolley.</p> <p>Ten medication charts were reviewed. Photo identification and allergy status was evident on all charts. All medication charts had been reviewed by the GP at least three monthly. All resident medication administration signing sheets corresponded with the medication chart.</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>FA</p>	<p>The service continues to maintain a high level of nutrition services. The residents' individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet, which meets their cultural and nutritional requirements. The food service is contracted to an external provider. The meals are cooked on-site.</p> <p>The external contractor has a summer and winter menu reviewed by a registered dietitian as per the contract and they also provide dietetic input into the provision of special menus and diets where required. A dietary assessment is completed on all residents at the time they are admitted. Residents with special dietary needs have these needs identified. Resource information on these diets is available in the kitchen and via the dietitian. Resident forums discuss food and feedback is given.</p> <p>Residents interviewed praised the meals.</p> <p>Special equipment is available such as lipped plates/assist cups/grip and built up spoons and on observing mealtimes, it was noted there were sufficient staff to assist residents.</p> <p>The kitchen was observed to be clean and well organised and all aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.</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>The RNs complete a variety of assessment tools on admission that link to the care planning software along with an interRAI assessment. All resident files sampled had an interRAI assessment. Assessments reviewed all provided consistent outcomes to each other, is an improvement on the previous audit.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are</p>	<p>PA Moderate</p>	<p>The long-term care plans reviewed were resident focused and integrated. Not all long-term care plans documented all required resident needs, this remains a finding from the previous audit. The facility uses an integrated document system where the GP, nurse practitioner, allied services, the RNs, occupational therapist,</p>

<p>consumer focused, integrated, and promote continuity of service delivery.</p>		<p>assistant diversional therapist, physiotherapist and other visiting health providers write their care notes in the resident's file/ on the computer software.</p> <p>Family members interviewed agreed that they had been involved in the care planning development and review process. Short-term care plans were in place for acute and short-term conditions and had been evaluated on a regular basis.</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>All resident files reviewed had nursing and lifestyle care plans in place (link 1.3.5.2). When a resident's condition changes, the RN initiates a GP/NP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status.</p> <p>Continence products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Care partners and RNs interviewed state there is adequate continence and wound care supplies.</p> <p>Wound care plans included an assessment, wound management and evaluation forms and a short-term care plan. There was an instance of three wounds on one form. Eight resident's wounds were documented on the day of audit; this included skin tears, chronic ulcers a bunion and a lesion. There were no pressure injuries.</p> <p>Monitoring charts were in use and examples sighted included (but not limited to): weight and vital signs, blood glucose, pain, food and fluid, turning charts and behaviour monitoring as required. However, monitoring and interventions were not always constantly documented.</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>	<p>FA</p>	<p>The service continues to implement a robust activities programme. There are two staff employed (one a diversional therapist (DT) and one activities assistant) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities five days per week with occasional weekend activities.</p> <p>A wide range of activities, addressing the abilities and needs of residents in the hospital and rest home, were offered. Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. The programme timetable was available to all, along with additional eye-catching material promoting specific activities to tempt residents to join in. Selwyn Oaks has implemented evening programmes to support residents with 'sun-downing'</p> <p>The service continues to be active with the Eden philosophy.</p> <p>The DT interviews each newly admitted resident on or soon after admission and takes a social history. This</p>

		<p>information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Clinical reviews were documented in the multidisciplinary review (MDR) records, which included input from the GP, RNs, occupational therapist, activities assistant, physio and resident/family. Progress notes were completed and reflected response to interventions and treatments. Changes to care were documented with exceptions (link 1.3.5.2).</p> <p>The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated.</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>A current building warrant of fitness is displayed in a visible location (expiry 26 March 2018).</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</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in Selwyn's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Selwyn head office for benchmarking. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the care lead. There have been no outbreaks since the previous</p>

control programme.		audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>There were no residents using restraints or enablers during the audit.</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of challenging behaviours.</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 Low	The service holds monthly resident meetings, monthly combined staff meetings and monthly registered nursing meetings. Minutes are kept for all meetings. Staff and residents interviewed report issues raised are followed up. Staff and management reported quality data trends including infection control, incidents, audit outcomes and complaints are discussed in meetings, but combined staff meeting minutes do not include this level of detail. RN meetings minutes are comprehensive and include quality improvement data information.	Combined staff meeting minutes do not include adequate information around quality data. Three months of meeting minutes describing quality data (June – August 2017) were identical. Meeting minutes held in the staff room were not up to date and no quality data was displayed.	Ensure that quality data is discussed and documented in the combined staff meetings.  90 days
Criterion 1.3.12.1	PA	The medication management system includes a	(i)On the day of audit two oxygen	(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>medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The medication room was clean and well organised. Staff discussed new processes in place to check, audit and monitor the medication room. These processes have very recently been commenced. Medication storage was identified as an area for improvement.</p>	<p>cylinders were observed to be not secured. (ii) Two eye medications had not been dated on opening and (iii) the sharps bin was stored in the medication trolley with the medication.</p>	<p>that oxygen cylinders are secure, (ii) eye drops are dated on opening and (iii) medications are stored in a clean environment.</p> <p>60 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The service is in the process of transitioning from paper-based documentation to software based. This has resulted in a temporary issue of some residents having paper-based files and some software and some having a combination of the two. Care partners interviewed were all very knowledgeable regarding all aspects of the resident's care needs. Discussion with staff and review of handover notes confirms that information to ensure safe care is communicated. Not all care plans reviewed reflected all resident needs.</p>	<p>For hospital level; (three resident files); (i) Three residents with identified skin integrity shortfalls lacked interventions to support resident needs. (ii) one care plan did not include pain interventions (where pain was an identified issue), (iii) one care plan did not include positioning for a resident with a hemiparesis, and (iv) one did not include information to manage the frailness of the resident's condition.</p> <p>For rest home level; (i) two rest home did not include sufficient interventions to manage disorientated/ behavioural issues and (ii) one did not include sufficient information around assistance with personal care and pain management.</p>	<p>Ensure that all interventions to support current assessed needs are documented</p> <p>60 days</p>
<p>Criterion 1.3.6.1 The provision of services</p>	<p>PA Moderate</p>	<p>Discussion with family members' evidences that the standard of care is high and that staff make all efforts</p>	<p>One resident has three wounds on one wound assessment and plan, so that</p>	<p>Ensure that there is one</p>

<p>and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>to ensure the safety and comfort of the residents. The GP stated that the standard of care was very good. One wound plan included three wounds and monitoring and interventions were not always documented as completed. This is a continued finding.</p>	<p>individual evaluation was no possible. One hospital level resident did not have behaviour monitoring consistently documented on the monitoring form and one rest home level resident's turning chart was not up to date.</p>	<p>wound per wound form, ensure that monitoring is consistently documented and up to date.</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.