

# Golden Concept E Limited - Eversleigh Hospital

---

## 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>	Golden Concept E Limited
<b>Premises audited:</b>	Eversleigh Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 13 December 2017    End date: 14 December 2017
<b>Proposed changes to current services (if any):</b>	To verify all 38-beds as suitable for dual-purpose use (hospital and rest home)
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	26

# 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

Eversleigh Hospital is owned and operated by Golden E Concepts Limited. The service provides care for up to 38 residents requiring hospital and rest home level care. On the day of the audit, there were 26 residents.

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. This audit also included verifying a further 33 beds at Eversleigh as suitable as dual-purpose beds (currently five identified as dual-purpose).

The facility manager has recently been employed she has health management experience and works full time. She is supported by the previous manager who has considerable experience in aged care and also a clinical nurse manager.

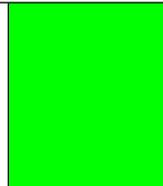
Residents, families and the general practitioner interviewed commented positively on the standard of care and services.

Ten of the fourteen shortfalls identified at their previous certification audit have been addressed. These relate to; post audit action plans, notifications, neurological observations, annual performance reviews, recruitment of staff, orientation of staff, admission agreements, the interRAI process, and some aspects of restraint. There continues to be improvements required around: completing internal audits, staff education, and aspects of restraint.

This audit has also identified four areas requiring improvement around: infection control surveillance, care planning and medication.

## 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.

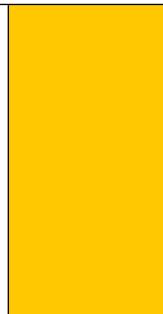


Standards applicable to this service fully attained.

Open disclosure is implemented by the service. Families are regularly updated regarding residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Eversleigh Hospital has business plan and a quality improvement with goals for the service that have been regularly reviewed. There is a quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme in place. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## 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>
---	--	---

All residents have a care plan in place which has been developed by registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with family/whānau involvement where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is an appropriate medication management system in place. 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.
--	--	--

The service displays a current building warrant of fitness, expiring 1st June 2018.

A review of staffing, the rooms, and communal areas evidences that the service is resourced appropriately to safely provide 38 dual service beds (hospital and rest home).

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
---	--	--

The service has policies and procedures to manage restraint and enablers to ensure they are safely used when required, and that enabler use is voluntary. There were nine residents using restraints and three enablers at the time of the audit.

## 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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

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.

## 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	5	0	0
Criteria	0	38	0	2	5	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 complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained using a complaints' register. Two complaints were reviewed for Octobers 2017 (the manager informed this was all the complaints for 2017). Both complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents (one rest home and two hospital) and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes. All 11-staff interviewed were able to describe the process around reporting complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility. The facility manager and supporting manager confirmed family are kept informed. Relatives (two hospital and one rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.</p> <p>All five resident related incident forms reviewed indicated family were informed or if family did not wish to be</p>

communication.		informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Eversleigh is owned and operated by Golden Concepts E Limited. Golden Concepts E Limited purchased the service in May 2015. The service provides rest home and hospital level care for up to 38 residents, which includes three rest home beds in the serviced apartments. This audit also verified all 38-beds as suitable for dual purpose use (hospital and rest home) including three beds in the serviced apartments (which are on the same floor). Since the previous audit, this has increased dual service beds from five to 38 and has included two additional resident beds.</p> <p>On the day of audit, there were 26 residents; one rest home level (in the serviced apartments) and 25 hospital level (including one respite resident). All residents were under the age-related residential care services agreement.</p> <p>The service has a business plan, which is reviewed regularly. The service has quality goals, which have been reviewed regularly. The facility manager is new to the service (one month) however the previous manager remains employed in a supporting role (she has significant experience in health management). The new manager has previous experience managing health services. The new manager is supported by a clinical nurse manager (registered nurse), with a background in aged care.</p> <p>The new manager has completed at least eight hours of professional development.</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 principles.</p>	PA Low	<p>Golden Concepts E Limited has an overall business/strategic plan and Eversleigh has a facility quality and risk management programme in place for the current year. The plan is robust and appropriate for the change to all dual service beds (hospital and rest home). The manager reports three monthly to the board. There is a service improvement plan in place which is reviewed and updated regularly.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (three caregivers, four registered nurses, one diversional therapist and the head cook and the house keeper) confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support both rest home and hospital level care.</p> <p>Facility meetings held include: monthly RN meetings, monthly staff/quality meetings, kitchen meetings, and also resident and relative meetings. Meetings minutes sighted continue to evidence there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and</p>

		<p>corrective actions.</p> <p>There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Not all internal audits have been completed as scheduled. This is an area that continues to require improvement. Corrective actions are developed, implemented and signed off, this is an improvement from the previous audit.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The (new) manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed around health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies.</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 accidents and incidents reporting policy. The (new) facility manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff / quality meetings. The clinical nurse manager conducts clinical follow-up of residents. Five residents, (falls related) incident forms sampled demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neuro observations had been completed as needed. This is an improvement on the previous audit. The facility manager was able to discuss the requirement to notify relevant authorities in relation to all essential notifications, this is an improvement on the previous 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>	PA Moderate	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (one registered nurse and four caregivers) and evidence that reference checks were completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. All five files documented annual appraisals, a job description, and an orientation on employment. This is an improvement on the previous audit.</p> <p>The facility manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Two of the five registered nurses have completed interRAI training with one more booked for training in January.</p> <p>Staff interviewed stated that training takes place and they are given training to care for resident's conditions.</p>

		There is a training schedule in place, however not all training has been provided and attendance is low when training is provided. This is continued finding from the previous audit.
<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>There is policy in place that determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The roster is flexible to adapt to changes in resident need and / or numbers including ensuring residents in the serviced apartments are supported. Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN, and clinical and facility manager who respond quickly to after-hour calls.</p> <p>An RN is available on call weekends and after hours and can contact the clinical nurse manager as required for clinical concerns. The facility manager (non-clinical) and the clinical nurse manager/RN are on duty during the day Monday to Friday. There is a RN on duty 24 hours. There are five caregivers on morning shifts plus an additional caregiver for a 'floating shift'. There are two long shifts and two short shifts on afternoon shifts and one on night shift.</p> <p>The management team described how staffing would be adjusted with the increase in dual-purpose beds.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The amendments made in 2015 to clause D13.3 of the ARRC contract, regarding refund timeframes are included in the admission agreement currently in use by the service. Four long-term resident files reviewed (one was a respite) all had an appropriate admission agreement in place. This is an improvement on 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 and safe practice</p>	PA Moderate	<p>There is a Medication management policy All staff that administer medication have received medication management training and competencies are completed. Not all medication is stored appropriately.</p> <p>The facility uses a packaged medication management system for the packaging of all tablets. Medication packs are check and signed on delivery form the pharmacy. Ten medication charts were reviewed. Not all medication charts reviewed evidenced photographs and not all had been signed as given to ensure clarity of administration.</p> <p>Medical practitioners wrote all medication charts correctly and there was evidence of three monthly reviews by the GP, however one resident had oxygen to be given as a care plan intervention, this was not documented in</p>

guidelines.		the medication chart. There were no residents self-medicating on the day of the audit.
<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>	FA	<p>All meals are cooked on site by the two cooks and four kitchen hands. All kitchen staff have completed food safety training. The menu has been approved by a dietitian. The dietitian also visits each month to review special menus (sighted). A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served directly from the kitchen to residents in the dining room or to their rooms as required. A tray service is available if required by residents. All food in the freezer and fridge was labelled and dated.</p> <p>All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes in association with a dietitian. Changes to residents' dietary needs are communicated to the kitchen staff. Alternative meals can be accommodated if needed. Residents' weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</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>	PA Moderate	<p>Service delivery is guided by the resident's plan of care. The interRAI assessment process and paper based assessments informs the development of the care plan. Care plans sampled were reviewed at six monthly intervals (for long-term residents). The staff interviewed stated that they have sufficient equipment and supplies to provide care.</p> <p>One palliative resident file sampled had a plan of care with all appropriate needs documented. The respite resident had a care plan in place. Not all care plan interventions or care delivered was documented in care plans. (Link also to 2.2.3.4 for restraint documentation and monitoring).</p> <p>There were seven residents with nine wounds at the time of the audit. Management plans and documented reviews were in place for six of seven wounds, not all assessments were fully documented.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available two days during the week to assist with mobility assessments and the exercise programme.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
Standard 1.3.7: Planned	FA	The service continues to employ an activities coordinator who works part-time over five days. Each resident has an individual activities assessment on admission and from this information, an individual activities plan is

<p>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>developed as part of the care plan.</p> <p>Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance. The activity coordinator described how the programme has been adapted over time to ensure higher needs residents have appropriate activities provided. Individual activities are provided in resident's rooms or wherever applicable.</p> <p>Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Residents enjoy activities including fortnightly bus trips, art sessions and entertainers. Walking sessions are provided in association with the visiting physio as well as an exercise programme. Local clergy visit those residents who wish them to visit. All long-term resident files sampled had a recent activity plan within the care plan and this was evaluated at least monthly and also when the care plan was evaluated.</p> <p>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>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. This was evidenced in one resident being re-assessed using interRAI and referred for hospital level care. Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. 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.</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>The service displays a current building warrant of fitness, expiring 1st June 2018. This audit also included verifying all their beds to provide dual-purpose (hospital and rest home) this includes three apartments. A review of staffing, equipment, observation of the environment, and communal area's evidences that the environment is appropriate, and the service is resourced appropriately to safely provide this service.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives,</p>	PA Low	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. An RN is the designated infection control coordinator. Monthly infection data is collected for all infections based swab results and pharmacy reports. Surveillance of infections is entered onto a monthly resident infection data sheet and then analysed and evaluated. Not all infections are collected. Outcomes</p>

priorities, and methods that have been specified in the infection control programme.		and actions are reported to the quality meeting. If there is an emergent issue, it is acted upon in a timely manner. Since the last audit, staff report there have been no infectious outbreaks.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were nine residents using a restraint, six with bedrails and three with lap belts. There were three residents using an enabler on the day of audit. Enablers had been classified correctly, this is an improvement on the previous audit. The files sampled document that enabler use is voluntary. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSPP/enablers has been provided (link to 1.2.7.5 for low attendance). Restraint has been discussed as part of quality meetings. A registered nurse is the designated restraint coordinator
Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	PA Moderate	The service policy requires that assessments are undertaken for residents who require restraint or enabler interventions. The restraint coordinator, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. In the four restraint files reviewed, assessments were not fully completed, one did not have an assessment and the process did not always document evidence of discussion of the risks associated with enabler or restraint use or consideration of other methods prior to the use of restraint. This is a continued finding.
Standard 2.2.3: Safe Restraint Use  Services use restraint safely	PA Moderate	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. Not all files reviewed had a completed assessment form and care plan that reflected risk (link to 2.2.2.1). Care plans reviewed did not all document the restraint in place and/ or the monitoring needed. Monitoring forms that included regular monitoring at the frequency determined by the risk level were not present in all files reviewed. The service has a restraint and enablers register, which is updated each month. This is a continued finding.
Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of	FA	The service reviews restraint as part of the internal audit and reporting cycle and as part of quality/ staff meetings. Reviews are completed six monthly or sooner if a need is identified. The restraint coordinator completes reviews. Any adverse outcomes are reported at the monthly quality and health and safety meetings. An annual review of restraint was currently in progress at the time of audit. This is an improvement on the previous audit.

restraint.		
------------	--	--

## 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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>There is an internal audit programme that covers all aspects of the service delivery. There is an audit schedule in place. Audits undertaken had an action plan as needed and had been actioned and reported to meetings. Not all internal audits have been completed as scheduled. This is an area that continues to require improvement.</p>	<p>Not all audits have been completed according to schedule. Examples include four audits for October and two for November.</p>	<p>Ensure that all audits are undertaken as scheduled</p> <p>30 days</p>

<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>The service has an annual education planner that has scheduled education to cover the requirements of the Age Related Resident Contract. Not all topics outlined on the schedule have been delivered. Where training has occurred, staff attendance has been low.</p>	<p>i) Not all training has been delivered for 2017 and since the previous audit, examples include; chemical safety, abuse and neglect, residents' rights, and cultural training.</p> <p>ii) Attendance has been less than 50 % for a selection of training, examples include; management of challenging behaviour, restraint, end of life, and emergency management.</p>	<p>i) Ensure that the education schedule is fully implemented and education is provided to cover all contractual requirements.</p> <p>ii) Ensure that a process is put in place to ensure that all staff attend mandatory education and where attendance is low an education follow-up plan is implemented.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <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>PA Moderate</p>	<p>The medication management policies comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. The new manager had</p>	<p>(i) There was an expired vaccine (not normally stocked by the service) in the fridge and expired cream in the medication trolley. (ii) Non-packaged medication was signed as a group rather than individually, making it difficult to be sure what was given. (iii) Two charts had no photo ID. (iv) Oxygen was a prescribed intervention</p>	<p>(i) Fully implement the checking process to ensure expired medications are not in stock. (ii)</p>

		<p>commenced a system of checking all medication on a regular basis, however there were expired medications sited in the fridge and medication trolley. Not all medication charts had photo ID, and signing of medication charts did not ensure clarity regarding what was given.</p>	<p>in the care plan, but not prescribed. It was not clear if the resident may had had it prescribed in the past.</p>	<p>Ensure that non-packaged medications are signed for individually. (iii) Ensure medication charts have photo ID. (iv) Ensure that medication charts and care plans reflect current care.</p> <p>30 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>The service has seven documented wounds, this includes four skin tears/scratches, and three chronic ulcers. Six of seven wounds have a management plan, not all assessments were fully complete. All five resident files had a care plan in place, however not all interventions reflected current assessed needs. Registered nurses (RNs) and caregivers follow the care plan and the RNs report progress against the care plan each shift.</p>	<p>(i)Wound care: one hospital level resident had no wound plan in place; one hospital level resident had no reference to the wound in the long-term care plan (or short-term care plan). Six of eight wound assessments are not fully completed.</p> <p>(ii) Two of three hospital and one of two rest home did not have all required interventions documented in the long-term care plans including; one resident continence needs, the need to two carer assist, behaviour interventions and monitoring, air mattress settings and sensor mat; One resident did not have the interventions for increasing frailness and the risk associated with warfarin use documented; one resident did not have location of pain and</p>	<p>(i)Ensure that wound management plans are documented for all identified wounds. Ensure that all wounds have a formal assessment and plan and that there are interventions documented in the short-term care plans or the long-term</p>

			nursing interventions documented and one resident did not have interventions for choking risk. (Link also to 1.3.12.1 for one resident with interventions for oxygen therapy in the care plan that is not prescribed in the medication chart).	care plan updated to reflect the wound.  (ii) Ensure that care plans document interventions for all resident assessed needs.  30 days
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>	PA Low	Monthly collection and collation of infections is implemented. The results are reported through facility meetings. Service policies document the classification identification and reporting of infections.	The IC coordinator collects infections based on swab results and pharmacy reports. The service IC definition process is not used. This means that only infections with a positive swab result or antibiotics are collected as part of infection surveillance data collected.	Ensure that policy is followed, and all infections collected, collated and reported.  60 days
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the</p>	PA Moderate	The registered nurse undertakes an assessment for residents requiring the use of a restraint or enabler; however, the assessments were not always fully completed. One file did not have an assessment, the risks associated with the use of the restraint or enabler	i) Three of four assessments did not document consideration of the risks associated with restraint. (ii) One (lap belt) did not have an assessment. (iii) Four of four did not document consideration of alternatives prior to the use of restraint.	Ensure that all residents with restraint have an assessment and assessments for restraint use identify and document the risks associated

<p>past and, if so, an evaluation of these episodes;  (e) Any history of trauma or abuse, which may have involved the consumer being held against their will;  (f) Maintaining culturally safe practice;  (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);  (h) Possible alternative intervention/strategies.</p>		<p>were not always documented and consideration of alternatives to restraint not documented.</p>		<p>with the use of the restraint or enabler and document consideration of alternatives prior to the use of restraint.</p> <p>30 days</p>
<p>Criterion 2.2.3.4  Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:  (a) Details of the reasons for initiating the restraint, including the desired outcome;  (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint;  (c) Details of any advocacy/support offered, provided or facilitated;  (d) The outcome of the restraint;  (e) Any injury to any person as a result of the use of restraint;  (f) Observations and monitoring of the consumer during the restraint;  (g) Comments resulting from the evaluation of the restraint.</p>	<p>PA  Moderate</p>	<p>Each resident using a restraint or enabler is required to have a restraint care plan in place; however, not all residents using a restraint, or an enabler had a restraint care plan in place. Not all monitoring required whilst using a restraint was documented.</p>	<p>(i) Two of four files did not include the use of restraint in the care plan. (ii) Three of four files did not have documented monitoring in place.</p>	<p>Ensure that care plans document the care and monitoring required for safe use of restraint and that monitoring is documented according to time frames</p> <p>30 days</p>

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

---

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

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

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

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

End of the report.