

Briargate Healthcare Limited - Briargate Dementia Care Unit

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 The DAA Group 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:	Briargate Healthcare Limited
Premises audited:	Briargate Dementia Care Unit
Services audited:	Dementia care
Dates of audit:	Start date: 27 March 2018 End date: 27 March 2018
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:	38

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

Briargate Dementia Care Unit (Briargate) provides rest home secure dementia care for up to 40 residents. The service is operated privately and is one of three facilities owned by the same providers. The current manager, who is a registered nurse, commenced the role in January 2018. He is supported by a registered nurse who works full time. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, and staff. The nurse practitioner was not available on the day of audit. Owing to the findings the number of residents' files reviewed was extended.

This audit identified nine areas requiring improvement relating to complaints management, two areas in relation to quality and risk management, one area related to human resources management, one area in service provision, three areas related to medication management and one area related to safe food management.

No improvements were required in the previous audit.

Consumer rights

<p>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.</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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The service demonstrated that it communicates effectively with residents and their relatives in a timely and open manner. The service adheres to the practice of open disclosure where necessary. There were appropriate processes in place to access interpreting services when required.

The complaints register showed written complaints are resolved promptly and effectively.

Organisational management

<p>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.</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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

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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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that meet the needs of the residents.

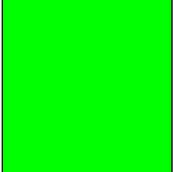
All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A medicine administration system was observed at the time of audit.

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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There is a current building warrant of fitness.

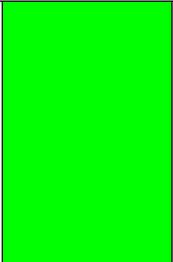
Restraint minimisation and safe practice

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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The organisation has implemented policies and procedures that support a restraint free environment. As this is a secure facility there are locked doors and secure outdoor areas for residents to use. No enablers or restraints were in use at the time of audit.

Documentation is available in policy should restraint be required. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	10	0	2	2	2	0
Criteria	0	30	0	4	1	4	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>	<p>PA Moderate</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed contained no information related to complaints received in 2017. The six monthly family meetings showed that several verbal complaints were raised and the company director stated the issues had been followed up. This information is not documented in the complaints register.</p> <p>One documented complaint which was dealt with via the Health and Disability Advocacy Service (January 2018) showed that actions taken, through to an agreed resolution, are documented and completed within the timeframes. The complaint was closed on 08 March 2018. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>FA</p>	<p>Family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Staff provide residents and families with the information they need to make informed choices and give consent. This was supported in residents' records reviewed and observations on the day of audit. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the</p>

<p>provide an environment conducive to effective communication.</p>		<p>requirements of the Code. There were seven residents for whom English is their second language and three residents whom affiliate with their Maori culture.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to staff knowing the residents well, use of family members and staff able to provide interpretation, for example, simple verbal and sign language cues as and when needed.</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>The strategic and business plans, which are fully reviewed bi-annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of quarterly management meetings minutes showed that organisational goals are discussed with senior staff and the directors of the company. This includes resources, objectives, anticipated problems/challenges and measuring success. Adequate information to monitor performance is reported to the directors by the facility manager on a monthly basis. However, no reports were sighted for December 2017 or January and February 2018. The director stated she was aware of the report information. The facility manager stated that he had not yet completed the February report but was able to produce all appropriate information.</p> <p>The service is managed by a registered nurse who holds relevant qualifications and has been in the role for two months. This is the first senior management role held by the facility manager. Responsibilities and accountabilities are defined in a job description and individual employment agreement. One director works at the facility and manages non-clinical issues. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through on-going regular education.</p> <p>The service holds contracts with Waitemata District Health Board (WDHB) for secure care for rest home level residents with dementia. At the time of audit there were 37 residents under the Age Related Residential Care contract and one resident under Long Term Support of Chronic Health Conditions.</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</p>	<p>PA Moderate</p>	<p>The organisation has a documented quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular family satisfaction survey, monitoring of outcomes, clinical incidents including infections and wound care and management of challenging behaviour. Not all policy requirements are being followed. Refer to comments in criterion 1.1.13.3.</p> <p>Quarterly quality meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the senior management level. Quality data information results is not shared with caregivers. Infection control benchmarking is undertaken by an off-site company.</p> <p>Staff reported their involvement in quality and risk management activities through implementation of corrective</p>

improvement principles.		<p>actions which are discussed at shift handover. Relevant corrective actions are developed and implemented to address identified shortfalls such as incident and accident follow up. One example related to the increase of falls in December of 2017 to 13. The corrective actions included ensuring a staff member being present in each lounge area for both morning and afternoon duties to supervise resident mobilisation, hourly room checks for each resident when they are in bed and keeping residents bedrooms clutter free. The quality data sighted shows that falls decreased following this corrective action implementation to 9. However, no evaluation of corrective actions have been documented.</p> <p>There is an internal audit programme documented but no evidence could be found that related to the implementation of this for 2017 or 2018.</p> <p>Family members confirmed during interview that they are surveyed verbally at the family meetings. This was confirmed in meeting minutes sighted. They are happy with the care and services offered.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed and supplied by an off-site provider and based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The director described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at daily handover and during staff monthly meetings as part of health and safety.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. The director advised there have been no notifications of significant events made to the Ministry of Health since the previous audit. They also stated there have been no police investigations, coroner's inquests, issues-based audits and any other notifications (eg, public health) since the previous audit.</p>
Standard 1.2.7: Human Resource Management	PA Low	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>practising certificates (APCs), where required. A sample of seven staff records reviewed showed that not all staff files contain orientation records. The staff files which did contain orientation records identified that all necessary components of service delivery were covered. Annual performance reviews were documented in all but one file reviewed.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. With the exception of one recently appointed caregiver, staff have completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB related to dementia care. There is one trained and competent registered nurse to undertake interRAI assessments and the facility manager RN has administration access only. Records reviewed demonstrated completion of the required training.</p>
<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>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. This was evident in the caregiver hours being increased when bed numbers increase. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of six weeks' of rosters confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is registered nurse cover at least five days a week.</p> <p>The facility manager works five days a week as does the RN. Roster show that the floor RN duties are carried out by the facility manager for holidays or when they are absent.</p> <p>There are two activities coordinators who cover seven days a week. Dedicated cleaners, laundry and kitchen staff work seven days a week.</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 High</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>An electronic system for medicine management was observed on the day of audit. The staff member interviewed had a good knowledge and a clear understanding of their role and responsibilities related to each stage of medicine management; however, this was not observed at the medication round on the day of audit. Not all staff who administer medicines had been assessed as competent to perform the function.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription, however not all medications sighted were within current use by dates.</p>

		<p>Clinical pharmacist input is provided as required.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided did not show evidence of weekly and six-monthly stock checks, however the entries sighted were accurate.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range, however the temperatures were not recorded each day.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review in the electronic medication device highlighted one resident overdue for review on the 13 March 2018, however evidence was provided to show that the nurse practitioner had seen the resident and medication review had occurred on the 12 March 2018.</p> <p>No residents were self-administering medication at the time of audit as appropriate for this service</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>The food service is provided on site by one of two cooks and kitchen staff and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines; however, certain areas of the kitchen interior need maintenance and cleaning, and the cleaning daily signing does not reflect the daily cleaning. The facility has not developed a food plan and are aware of the new deadline of the 30th June 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the facility have access to food and fluids to meet their nutritional needs at all times. All meals are cooked and served directly from the kitchen and served in the adjacent dining room. Residents have the option of trays in their rooms, however all residents are encouraged to have their meals in the dining rooms to encourage appetites and socialisation. Evidence of resident satisfaction with meals was verified by family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>FA</p>	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident however not all residents were supported as needed re: pain, weight and wound management (please see criterion 1.3.3.3). The GP and NP were unavailable to be interviewed at the time of audit. Care staff confirmed that care was provided and outlined in documentation and this was evident at the time of audit in daily resident progress notes which included specific interventions for challenging behaviours and daily care log for personal cares. A range of equipment and resources was available, suited to the level of care provided and in accordance with the 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>	<p>FA</p>	<p>The activities programme is provided by one diversional therapist and supported by a caregiver who is also a qualified diversional therapist. The activities team support residents Monday to Sunday from 8.30am to 5.00pm. After hours, staff have access to activities at all times and integrate daily living with activities while supporting residents.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three monthly and as part of the formal six-monthly care plan review.</p> <p>Activities are provided for residents who present with challenging behaviours and are specific to the needs and abilities of the people living there and care plans identify the resident's individual diversional, motivational and recreational requirements over a 24-hour period. Activities are offered at times when residents are most physically active and/or restless and the activities calendar remains flexible to accommodate the residents' day to day unpredictable challenging behaviours. The facility also provides a van ride for residents five days a week. Families interviewed confirmed they find the programme excellent and stimulating for the residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and there is evidence of working documents throughout the eight residents' files reviewed however this was not evident for one resident with ongoing pain and one resident who was admitted with bilateral leg wounds (see criterion 1.3.12.1). Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and challenging behaviours. When necessary, and for unresolved problems, long term care plans are added to and updated.</p>

		Families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<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	A current building warrant of fitness, expiry date 23 January 2019, is publicly displayed.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of cold, flu, chest infections, bronchitis, pneumonia, eye/ear/mouth, urinary tract infections, diarrhoea, gastroenteritis, skin, wound and scabies infections. The IPC coordinator/registered nurse reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Individual residents who present with an infection are discussed at staff handover. Results of the surveillance programme are not shared with staff via regular staff meetings. Refer comments in criterion 1.2.3.1. Statistics are produced that identify trends for the current year and this is reported to the facility manager and owners.</p> <p>The facility has had a total of 11 infections since October 2017. Two residents have been identified with frequent infections due to co-morbidities. The two residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The facility is a secure unit and this is clearly described in the consent form signed and explained as part of the admission procedure. This was confirmed during interview.</p> <p>On the day of audit, no residents were using additional restraints or enablers. Enablers are described in policy as the least restrictive equipment, devices or furniture voluntarily used by residents.</p>

		Staff education focuses on the management of challenging behaviours and was undertaken in May 2017. During interview staff verbalised a clear understanding of what is restraint and confirmed it is not used at the facility.
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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 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	<p>PA</p> <p>Moderate</p>	<p>There is a complaints register which showed one complaint for 2018. Timeframes were met in responding to the complaint and the corrective actions put in place resolved the issue raised. No documentation for two verbal complaints received in 2017 could be located at the time of audit. Staff meeting minutes reviewed contained no evidence about complaints. The director stated that corrective actions were put in place related to the verbal complaints, but no evidence could be found.</p>	<p>Two complaints raised at the six monthly family meetings are not documented in the complaints register. One relates to loss of personal belongings and one is about a resident who enters other residents' rooms.</p>	<p>Provide evidence that all complaints are documented in the complaints register.</p> <p>60 days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and</p>	<p>PA Low</p>	<p>The organisation's policies identify the quality and risk management systems. When staff were asked about the systems they understood corrective action management but knew nothing about internal audit</p>	<p>Staff meeting minutes do not include quality</p>	<p>Provide evidence that quality and risk management</p>

<p>risk management system which is understood and implemented by service providers.</p>		<p>systems or whether quality data indicated that issues, such as falls or infections, had improved or not improved over the last year. They thought that falls had decreased.</p> <p>There is a documented internal audit calendar, but no audit results could be located on the day of audit and staff interviewed indicated internal audits are not undertaken.</p>	<p>improvement data information and staff knowledge of the quality and risk systems in place was limited. No documented results could be found relating to internal audits being undertaken for 2017-2018. Staff have limited understanding of the quality and risk management system and are unaware of collated monthly quality data findings.</p>	<p>systems are fully implemented to meet policy requirements and that staff have a better understanding of quality and risk processes that operate throughout the organisation including knowledge of collective quality data information.</p> <p>90 days</p>
<p>Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Low</p>	<p>Quality improvement data are collected and analysed. No formalised documented evaluation was sighted for the corrective actions. For example, the data identifies that the number of falls had decreased since corrective actions were put in place. The auditor gained this information by checking each months number of falls and making a comparrison. Staff were not aware that fall numbers had decreased but stated they may have done so owing to better supervision now occurring for residents in the lounge area. Other corrective actions taken are not evaluated. For example, one resident who displayed inappropriate behaviour was managed with input for Mental Health Services for the Older Adult and whilst all recommendations were implemented no documented evalaution of the outcome was noted.</p>	<p>Quality data evaluation outcomes for corrective actions put in place are not shared with all staff.</p>	<p>Provide evidence that all quality data collected is shared with staff along with documentation of evaluation of corrective action outcomes.</p> <p>90 days</p>
<p>Criterion 1.2.7.4 New service providers receive an</p>	<p>PA Low</p>	<p>There is an orientation book which covers essential components of service. This was not always competed by staff. The recently appointed facility manager stated he had completed an orientation but that is was</p>	<p>Two of seven staff files reviewed did not contain documented</p>	<p>Provide evidence that all staff have completed an</p>

<p>orientation/induction programme that covers the essential components of the service provided.</p>		<p>never documented. Staff interviewed stated they receive a three day orientation. One annual appraisal in the records reviewed was overdue.</p>	<p>orientation records. One staff member's annual appraisal was overdue by four months.</p>	<p>orientation and that the schedule of staff appraisal dates is implemented.</p> <p>180 days</p>
<p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA High</p>	<p>The staff knew the residents well and when interviewed could recall the proper procedures required when administering and supporting residents with medication. A resident was charted a narcotic pro re nata (prn). The caregiver interviewed stated that 'this medication is only provided if there are two medication competent staff on at the time, otherwise the resident just has to do with Panadol'. The caregiver confirmed that they would not ring the registered nurse or facility manager but were unable to say why. There was evidence of this medication been administered (in the controlled drug book) and checked by two caregivers only on the following dates: 25 March 2018, 28 March 2018, 27 March 2018, 26 February 2018, 25 February 2018, 21 February 2018, 20 February 2018, 18 February 2018, 13 February 2018 (this medication was administered on these dates at 7.30pm). In checking the progress notes and the electronic medication device there was no evidence of pain documented nor outcome of pain relief. The facility manager/registered nurse interviewed did not know why this medication was prescribed as PRN, given the resident was requiring this medication on a more regular basis.</p> <p>Two residents were prescribed insulin. The senior caregiver interviewed stated that insulin is checked with another medication competent staff member; however this was not documented with a second signature and was not evidenced at the time of audit.</p> <p>There was no evidence to show that the facility provides a weekly stocktake of the controlled drugs.</p> <p>A Glucagon pen found in the treatment room had expired in May 2017.</p> <p>The facility requests that the medication fridge temperatures are recorded daily. The monitoring chart sighted showed that for six days in</p>	<p>Medication administration processes were not undertaken in accordance with the organisational policy and good practice in relation to administration, storing, checking of medication and documentation of fridge temperatures.</p>	<p>Provide evidence of safe medication management.</p> <p>1 days</p>

		<p>March the fridge temperature was not recorded.</p> <p>While observing the medication round at the time of audit, the caregiver who has an up to date medication competency was observed to not be checking the robotic medication on the electronic device before administering to the residents. The caregiver did not wear the provided medication apron. The caregiver was also attending to other tasks at the time of the medication round.</p> <p>A newly admitted resident did not yet have medication entered into the medication electronic device and the caregiver was observed to administer the medication to the resident without first checking a hardcopy prescription.</p>		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA High	<p>The registered and care staff interviewed were able to discuss safe medication management and were aware of the policy's around medication; however, the facility manager/registered nurse, registered nurse and three caregivers administering medication did not have an up to date medication competency. The medication competent morning care staff member was called back to the facility to support afternoon medication, the facility manager/registered nurse interviewed stated that the following day they would contact a registered nurse from another facility to support with medication competency checking for the staff highlighted.</p>	<p>No all staff administering medication to residents had completed and/or had an up to date medication competency assessment.</p>	<p>Provide evidence that all staff administering medication are competent to do so.</p> <p>1 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and</p>	PA High	<p>A respite care resident admitted on the 23 March was being administered blister-pack medication without a prescription. The facility manager/registered nurse interviewed stated that the family had been asked to provide a prescription at time of admission. The facility manager was unable to show documented evidence of this discussion nor had the facility made contact with the residents GP to request an updated prescription.</p>	<p>A resident administered medication by facility staff did not have a supporting prescription provided by a GP.</p>	<p>To ensure that all medications administered to residents at the facility have evidence of a supporting prescription to meet legislation and best medicine guidelines.</p>

guidelines.				1 days
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	<p>The cook and kitchen assistant interviewed stated that they were aware of the requirements re-signing of the cleaning schedule once required cleaning complete. However, the cleaning schedule was sighted as signed of and completed by the kitchen staff for the entire month of March 2018. The kitchen assistant interviewed stated that this is 'common practice'. There are four areas of the kitchen ceiling panels that have come loose. Upper walls and pull-down screen for the servery needs cleaning and rust was observed on hinges holding up the shelving.</p>	<p>The kitchen requires some maintenance and the cleaning schedule was not accurately signed as completed.</p>	<p>Provide evidence that the cleaning schedule is maintained daily and signed in acknowledgement of the work completed. There is a plan in place detailing maintenance required and this is completed as needed.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA High	<p>Two residents admitted on the 23 March 2018 did not have an initial assessment or short-term care plans created by a registered nurse. One resident did not have a wound plan for multiple bilateral leg wounds. One resident who was admitted in November 2016 had an admission agreement which includes all consents but was not signed by the EPOA and/or resident. One resident had evidence of weight loss with no evidence of follow-up intervention, support and/or documentation. One resident was admitted on the 23 March 2018 but had been admitted by the GP at time of audit. No evidence of notification of level of care was sighted for the eight residents' files reviewed. A caregiver wrote in the admitting progress notes that the resident was on a fluid balance, however no evidence of a fluid balance could be found. The facility manager interviewed stated that 'this must be old information as I did not verbally hand this over'. Four of eight files reviewed had evidence of resuscitation discussed.</p>	<p>Not all residents were admitted to the facility by a registered nurse or GP within required time frames. Not all residents had supporting management plans for wound management or weight loss. Not all residents had evidence of documentation for example resuscitation, the</p>	<p>To provide evidence that each stage of service provision (assessment, planning, provision, evaluation, review) are completed within timeframes to meet contractual, legislative requirements and good practice.</p>

			required notification of level of care or admission agreement which included consents.	7 days
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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.