

Maygrove Care Limited - Maygrove Village

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: Maygrove Care Limited

Premises audited: Maygrove Village

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 24 July 2018 End date: 24 July 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: 49

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

Maygrove Care Limited known as Maygrove Village provides rest home and hospital level care for up to 50 residents. The service is operated by Maygrove Care Limited and the care unit is managed by a hospital manager who is assisted by the clinical manager. Both managers are registered nurses with current practising certificates and have been in their roles for three years. There is a village on the same site which is not included in this audit. 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, staff, and a general practitioner.

This audit identified four areas requiring improvement relating to evaluation of quality data, medication management and evaluation of effectiveness of pain relief, which was also identified at the previous audit. Improvements have been made to short term care planning, addressing the other area requiring improvement at the previous audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to formal interpreter services if required.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

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

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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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 of care, transfer and review are provided within time frames that safely meet the needs of the residents and contractual requirements.

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 village 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 six-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. Medication competency for all staff administering medication is completed annually. There is an implemented process for comprehensive analysis of any medication errors.

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 policies and procedures related to safe restraint practices. No enablers were in use at the time of audit. There were 21 restraints in use. (Four residents had two restraints one bedside rail and one chair lap belt). A comprehensive assessment, approval and monitoring process with regular reviews occurs. Policy identifies that the use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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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	14	0	1	2	0	0
Criteria	0	36	0	2	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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 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 understood the process.</p> <p>The complaints register reviewed showed that six complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. The hospital 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. There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and 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. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak English. There are four residents with a significant sensory impairment and appropriate equipment and</p>

<p>provide an environment conducive to effective communication.</p>		<p>resources were sighted and highlighted in residents' long-term care plans reviewed.</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 quality and business plans, which are reviewed annually, outline the purpose, values, direction and goals of the organisation. The documents describe annual and longer term objectives and the associated operational plans. A sample of monthly reports to one director, who then takes the information to the board, showed adequate information to monitor performance is reported, including financial performance, occupancy, environment and equipment, staffing, staff education, human resources management including annual appraisals, emerging risks and issues. The hospital manager has a meeting with the director at least once a week and meeting topics are kept in a diary.</p> <p>The service is managed by a hospital manager who holds relevant qualifications and is supported by a clinical manager who is also a registered nurse. Both managers have been in their positions for three years. Responsibilities and accountabilities are defined in their job descriptions and individual employment agreements. Both managers confirmed their knowledge of the sector, regulatory and reporting requirements and maintains currency through regular ongoing clinical and management related education such as attendance at the New Zealand Aged Care Association meetings, Waitemata District Health Board (WDHB) education and meetings and in-house education and competencies related to their roles.</p> <p>The service holds an Age-Related Residential Care contract with WDHB for rest home, hospital and respite care. This allows palliative care to be undertaken. Forty-nine residents were receiving services under the contract (two rest home level care and 47 hospital level care) at the time of audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>PA Low</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, recording and collation of clinical incidents including infections, wounds and falls.</p> <p>The quality committee meeting minutes reviewed confirmed regular review and analysis of quality indicators. There are specific committees such as infection control, health and safety and restraint that report findings to the quality meeting and to the director as required. Whilst this information is recorded, graphed and placed on the staff notice board there is no documented evidence that it is discussed at staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and the implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. However, evaluation of corrective actions implemented are not documented.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey (April 2017) gained a 95.5% overall satisfaction rating. Issues identified have been addressed. One example of a corrective action being</p>

<p>principles.</p>		<p>undertaken as a result of satisfaction survey results relates to weekend cleaning were a family member identified that the facility cleanliness was less than during the week. This has resulted in a change to the roster for the days cleaning is undertaken and now includes a dedicated cleaner on Saturdays and allocated cleaning hours for the laundry person on a Sunday. A food satisfaction survey (January 2018) identified that residents were not always being given a hot wash towel prior to every meal. Staff were reminded about this and no further concerns have been raised. One resident stated they did not like the evening meal but when this was raised with residents they could not itemise any specific meals. There is a communication book for meals and any concerns raised are discussed at a weekly meeting with the hospital manager and the village kitchen manager. No complaints related to meal services arose during resident and family interviews on the day of audit.</p> <p>Policies reviewed cover 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 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. Policies sighted were up to date.</p> <p>The health and safety champion, hospital manager and clinical manager 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. An up to date risk register is in place which includes a hazardous substance register. Any new hazards are discussed and managed by the health and safety committee and entered into the risk register as necessary.</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>	<p>FA</p>	<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 to the quality committee and the director. Staff confirm they are made aware of any corrective actions required to be put into place at shift handover. (Refer comments in 1.2.3.6 related to evaluation of outcomes).</p> <p>The hospital manager described essential notification reporting requirements, including for pressure injuries. They advised there have been two section 31 notifications of significant events made to the Ministry of Health since the previous audit. In December 2016 a police investigation commenced related to a resident's missing jewellery. This was closed in July 2017 when the jewellery was found at the public hospital in a ward safe. In April 2018, a sudden death following a choking incident was also notified using a section 31 process. The facility undertook a full investigation and it was deemed that all correct actions had been taken. The resident's family were in attendance at the time this occurred, and they were happy with the actions taken. Documentation includes the ambulance care summary to support the facility's findings. Both instances are clearly documented to show the actions taken.</p> <p>There have been no coroner's inquests, issues-based audits or public health notifications since 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>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after three-months and then annual appraisals are undertaken.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member is the internal assessor for the programme. There are five trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of the annual interRAI performance appraisals.</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). InterRAI acuity data reports identify staffing ratios meet the needs of residents. The facility adjusts staffing levels to meet the changing needs of residents. An afterhour 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 a four-week roster cycle 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 24//7 RN coverage.</p> <p>Staff who have specific responsibilities related to restraint, infection control and interRAI have identified time to undertake these additional tasks. Registered nurses work either a 7.75 hour shift for mornings and afternoons and an 8.25 hour night shift seven days a week. Caregivers work between six and 7.5 hours per shift. There is a dedicated activities coordinator who works from 9 am to 3.30 pm Monday to Friday. Laundry staff work 6.30 am to 3 pm seven days a week. Cleaning staff work either 7 am to 3 pm or 8 am to 4 pm Monday to Friday and one staff member works 7 am to 3 pm Saturday. Administration staff work 9 am to 4 pm three days a week and 9 am to 3 pm one day a week. The administration assistant works 9 am to 4 pm Monday to Friday.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>PA Moderate</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>A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage, however at the time of audit, the medication trolley was observed to be left unattended during two separate medication rounds by the registered nurse.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription when administering to residents however when medication is received initially from the pharmacy the medication is not reconciled. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</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 evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</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 was consistently recorded on the medicine chart. Standing orders are used however do not comply with the facility's medication policy.</p> <p>There are five residents who self-administer medications at the time of audit. Appropriate processes are not in place to ensure this is managed in a safe manner.</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>FA</p>	<p>The food service is provided on site by the village kitchen manager, three other cooks and kitchen team 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. The kitchen observed and sighted at the time of audit appeared clean and tidy. The service operates with a food safety plan with grade pending; registration was issued by the Auckland Council which expires 29 June 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</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</p>

		<p>staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and satisfaction surveys. 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 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of short and long term care plans.</p> <p>The previous audit identified an area for improvement to ensure that short term care plans are consistently developed when residents have changing care needs including infections and new episodes of pain. The corrective action is now addressed, and records were available to demonstrate that residents commenced on a new pain medication or antibiotic due to an infection have an initial short-term plan developed.</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>	FA	<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 in all areas of service provision; however, not all residents had documentation to show that their pain, having had pro re nata medication had been evaluated (see criterion 1.3.8.2). One GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels 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</p>	FA	<p>The activities programme is provided by an activities co-ordinator and four regular community volunteers. The activities co-ordinator supports the residents from 10 am – 3 pm Monday to Friday.</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-</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through the weekly residents' 'coffee group' and satisfaction surveys. Residents interviewed confirmed they find the programme interactive.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Residents' 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. Examples of short term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for wounds and infections. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p> <p>The previous audit identified an area for improvement to ensure that pain assessments and evaluations are consistently undertaken when residents are given additional medications for episodes of pain. The corrective action has been partially addressed but further improvements are required.</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>	<p>FA</p>	<p>A current building warrant of fitness (expiry date 16 June 2019) is publicly displayed.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infections, respiratory tract infections, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed. In April of 2018, 36 residents and 24 staff consented and had the flu vaccine.</p>

<p>with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>Monthly surveillance data is collated and made available for staff to read and sign to acknowledge they have read the information on the staff room notice board. The manager interviewed stated that this information is also discussed at handover; however, no evidence of this was sighted at the time of audit. Trends are identified from the past year and this is reported to the quality committee. Staff meeting minutes do not show that this information is verbally communicated to staff or that monthly surveillance is evaluated or trended (Refer criterion 1.2.3.6). The facility has had a total of 115 infections since January 2018. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infections. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. Benchmarking does not occur.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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 restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, 17 residents were using restraints. Four of the 17 had two restraints one being a bedside rail and one a chair lap belt. No residents were using enablers. Policy describes enablers as the least restrictive method of restraint used voluntarily at residents' requests to enable independence and safety.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This occurs in consultation with family and the resident. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. Staff competencies are undertaken annually for the safe use of restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</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>Quality improvement data are collected, analysed and reported at the quality committee meetings. Specific data related to incident and accidents, complaints, infection control, health and safety and restraint are graphed and trended against data from the previous year for the same month. If there is a marked increase in the data collected, management confirmed this is addressed. However, at the time of audit, no documented outcomes were sighted to show if the corrective actions put in place improved services. One example relates to a quality goal of decreasing falls by 8% over a 12-month period. All actions are shown, and the outcome was marked with the word 'achieved'. (At the time of audit all data was written up and showed that over 12 months falls had decreased from 249 to 210 which is a 17.5% decrease).</p> <p>The graphed quality data is placed on the staff notice board but staff meeting minutes do not identify that the results are discussed. During staff interviews they acknowledged that they knew where to find the data and confirmed they sign to say they have read the information.</p>	<p>Quality improvements and quality data trending outcomes are not evaluated to identify if the corrective actions put in place have improved services. Staff meeting minutes do not show that quality data</p>	<p>Provide evidence that quality improvements are evaluated, and that quality data findings and trends are discussed with staff at meetings.</p> <p>90 days</p>

			information is verbally communicated or discussed with staff.	
<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 staff interviewed knew the residents well. All GP reviews were up to date including medication reviews on the medication electronic device. All changes in medications are discussed at staff handover. Staff interviewed could recall the proper procedures required when administering and supporting residents with medication and this was also observed at the lunch time medication round by a registered nurse. However, when medication is received by the facility from the pharmacy via blister packs the medication is not reconciled.</p> <p>The staff interviewed could recall the safety procedures required when administering and supporting residents with medication, however on two occasions during the audit the medication trolley was observed to be unattended. This occurred once when initially being shown around the facility and the second time when observing the registered nurse, at frequent intervals while administering lunchtime medications to the residents. The medication trolley was locked at these times; however, there were liquid filled medication bottles located on the side of the trolley and the electronic device was open identifying the resident and their prescribed medication.</p> <p>The facility has a policy for standing orders which identifies annual review and updates of all standing orders by the attending GP. All five GP's have access to the medication electronic device, however it was identified by a registered nurse, that a standing order medication which is rarely utilised since the implementation of the electronic device, had been administered one day ago. This standing order had not been updated, reviewed or signed by the GP since 2016.</p>	<p>Reconciliation of medications is not occurring when new medications supplies are delivered to the facility.</p> <p>The medication trolley is not always supervised during the medication round.</p> <p>The GP standing orders for one GP does not reflect the medication policy which states annual reviews.</p>	<p>Provide evidence that all medication practices meet the medication guidelines for safe medication practice.</p> <p>30 days</p>
<p>Criterion</p>	<p>PA Low</p>	<p>Five of five residents had an assessment completed to assess for competency of self-</p>	<p>Three of five</p>	<p>Provide</p>

<p>1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>		<p>administration of medication. The assessment was signed by the admitting RN and GP at the time, and subsequent assessments have been completed three-monthly. Observation on day one of the audit, showed that three residents do not have a key for the locked drawer and one resident does not have access to a locked draw in their bedroom to safely store their inhalers and eye drop medication. In discussions with the residents and staff it was evident that the residents are competent in the self-administering of their medication and evidence was provided to show three-monthly GP reviews that included review of the resident's medication.</p>	<p>residents who are self-administering medication do not have a key for the locked drawer and one resident does not have access to a locked draw to safely store their medication.</p>	<p>evidence that safe self-administration of medicines is maintained.</p> <p>30 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>The staff knew the residents well and when interviewed could recall the proper review procedures required when administering and supporting residents with medication. The clinical manager interviewed stated that residents with pain and outcomes for the residents are discussed verbally at handover. Residents and family members interviewed stated that they were very happy with the care provided. An audit completed for the week of the 24 July 2018 where 88 episodes of pro re nata pain medication was administered, identified that there was an 87.5 percent compliance to show that residents administered pro re nata medications had had their pain evaluated for effectiveness. It was documented in the corrective action that the clinical manager spoke to staff, however there was no evidence to show when this occurred and how many staff were present at the discussion. Evidence at the time of audit was provided to show three-monthly GP reviews that included the resident's pain and medication reviews were up to date and that all residents commenced on a new pain medication have an initial assessment to show effect. Despite this, for the month of July, there was no evidence documented in the medication electronic device, Staff handover notes or the resident's progress notes to show evaluation of pro re nata pain relief administered to residents. For example, for the 23 July 2018, the medication electronic device showed that nine residents required a total of 17 prescribed pro re nata medications with no evidence of review and/or evaluation of the medications' effect.</p>	<p>There is no documented evaluation of outcome and effect of pro re nata pain relief given.</p>	<p>Provide evidence that pain relief administered as prescribed has an outcome documented to identify the effectiveness of the medication given.</p> <p>60 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.