

Mossbrae Healthcare Limited - Mossbrae Healthcare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Mossbrae Healthcare Limited
Premises audited:	Mossbrae Healthcare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 November 2018 End date: 7 November 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:	56

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

Mossbrae Healthcare is certified to provide hospital (geriatric and medical) and rest home level care for up to 64 residents. On the day of audit there were 56 residents.

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

The facility is managed by a general manager (non-clinical), who is supported by a clinical manager (registered nurse). There is an experienced registered nurse who supports the management team. The general manager reports twice monthly to the facility owners, who visit the facility at least monthly.

The service has addressed three of the seven shortfalls from the previous audit around corrective actions, food service and restraint monitoring. Further improvements continue to be required around wound management and medicine management. This audit also identified improvements required around reporting at meetings, reference checking and meeting timeframes.

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

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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A general manager and a clinical manager are responsible for the day-to-day operations of the facility. Quality and risk management processes are documented. Quality goals are documented for the service. Internal audits are completed.

A health and safety programme is in place, which includes incident and accident reporting and health and safety processes.

Residents receive appropriate services from suitably qualified staff. An orientation programme is in place for new staff. Registered nursing cover is provided 24 hours a day, 7 days a week. There are adequate numbers of staff on duty to ensure residents are safe.

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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Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. The care plans are resident and goal orientated, and evaluated every six months or earlier if required, with input from the resident/family as appropriate. Allied health and a team approach are evident in the resident files reviewed. The general practitioner reviews residents at least three monthly.

The activity coordinators implement the activity programme in the rest home/hospital to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are entertainers, outings, and celebrations.

There are policies and processes that describe medication management. The registered and enrolled nurses, and senior healthcare assistants administer medications and have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

All meals are cooked off site by a contracted service. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and modified dietary needs are being met. There is dietitian review of the menu.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

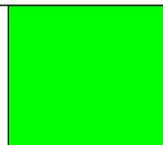


Standards applicable to this service fully attained.

The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services.

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.

There is a restraint policy that includes restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. There are currently four residents who require the use of a restraint and seven residents who have requested the use of an enabler. Staff are trained in restraint minimisation.

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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	3	3	0	0
Criteria	0	38	0	3	4	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>	<p>FA</p>	<p>The service has a complaints policy and complaints process. There are complaint forms available. Information about complaints is provided on admission. Interview with residents and relatives demonstrates an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. There were seven complaints in 2017, including two lodged with the health and disability commission (HDC). One of these complaints is ongoing, the other has been resolved to the satisfaction of the complainant. Five complaints have been received in 2018. No trends were identified. Verbal and written complaints are documented. All complaints have documented: investigation, timelines, corrective actions when required and resolutions. Results are fed back to complainants. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p> <p>The Ministry requested follow up against aspects of a HDC complaint that included procedures for respite residents, care interventions, Code of Rights training, discharge processes and GP charting for respite residents and medication documentation. This audit has identified issues with care interventions, GP charting and medication documentation.</p>
<p>Standard 1.1.9: Communication</p>	<p>FA</p>	<p>Information is provided at entry to residents and family/whānau. Five residents interviewed (four hospital and one rest home) stated that they were welcomed on entry and were given time and explanation about the services and</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>procedures. The general manager and clinical manager are both available to residents and families and they promote an open-door policy. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Seven incident forms reviewed evidenced that family had been notified on all occasions. Three family (hospital level) advised that they are notified of incidents and when residents' health status change. Residents and relatives interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Interpreter services are available 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>Mossbrae Healthcare is privately-owned, and the owners have recently purchased another age care facility. Mossbrae is certified to provide rest home and hospital (geriatric and medical) level care for up to 64 residents (there are six rest home level beds and 58 dual purpose). On the day of audit there were a total of 56 residents, with six rest home residents (including one on a respite care contract), and 50 residents at hospital level care. All residents were under the ARCC contract.</p> <p>The facility has a business, quality and risk management plan which has specific annual quality goals identified that link to the business plan and are reviewed quarterly.</p> <p>The general manager (not clinical) has been in the role since May 2018 and prior to this was the assistant manager with a quality management focus. A clinical manager (RN) has been in the role since February 2018, and supports the general manager. There is a job description for the clinical manager position that includes responsibilities and accountabilities. The general manager advised that the owners visit at least monthly and are available by email or telephone at any time. A weekly management report is completed by the general manager and forwarded to the owners. The general manager and clinical manager have maintained at least eight hours annually of professional development activities related to managing an aged care facility</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 Low</p>	<p>The service has a documented quality and risk programme and business plan in place for 2018, which includes the service philosophy, general objectives and lists the quality activities. A combined quality, infection control and health and safety meeting is held on a two-weekly basis with the owners, managers and clinical managers from Mossbrae and their other facility. Quality improvements and policy review and alignment between the facilities are discussed with changes communicated at the monthly all staff meetings, as evidenced in the meeting minutes. The service has recently developed a process and flow chart to guide the RN's and staff around respite admission (link 1.1.13).</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls, infection rates, complaints received, restraint use, pressure injuries, wounds and medication errors. Quality and risk data, including trends in data are discussed in the two-weekly combined quality meetings, monthly registered nurse (RN) meetings and staff meetings. An annual internal audit schedule is implemented. Corrective</p>

improvement principles.		<p>actions are established, implemented and are signed off when completed. The previous shortfall has been addressed. Infection control data is collated monthly and reported to staff. Staff interviewed were knowledgeable around infection prevention and control.</p> <p>Resident and relative meetings are held on a quarterly basis with follow-up of issues. Relatives interviewed confirmed that this is happening, with a meeting scheduled for the evening of the audit. Resident meetings are held three monthly. Resident surveys were last conducted in February and October 2018, with respondents advising that they are overall very satisfied with the care that residents receive. A relative survey was conducted in September 2018. Results of the surveys are available for residents and families on noticeboards, however feedback was not documented as provided to staff.</p> <p>The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The GM is the health and safety officer. The service collects information on resident and staff incidents and accidents. Interviews with staff confirmed staff understanding of the quality systems, and current initiatives. There are a variety of meetings held on a monthly basis such as all staff, allied health, RN/clinical. Falls prevention strategies include the analysis of falls events and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention equipment includes sensor mats and chair alarms.</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	Click here to enter text
Standard 1.2.7: Human Resource	PA Low	There are human resource management policies in place, which include that relevant staff checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Six staff

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>files selected for review included the clinical manager, one diversional therapist, two healthcare assistants (HCA), and two registered nurses (one new to the service). The files evidenced that the required documentation, including orientation and annual performance appraisals, are all completed as required. One staff file new to the service and annual appraisal was not required. However, there was no evidence of referee checks on file.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 has been completed and the 2018 programme is being implemented, however, there are gaps within the education plan, with some compulsory sessions not planned for. There has been to date, less than 50% attendance at compulsory education sessions held, however the service has implemented a new initiative to have education sessions at the end of the staff meetings and attendance has increased since this has been implemented. The clinical manager and registered nurses can attend external training, including sessions provided by the local DHB.</p> <p>There are four of nine registered nurses, including the clinical manager, who are interRAI trained and have maintained competency. Not all interRAI assessments have been completed within the required timeframes. This is an ongoing area for improvement (link 1.3.3.3).</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>Policies include staff rationale and skill mix. Sufficient staff are rostered on duty to manage the care requirements of the residents.</p> <p>There are two registered nurses on shift in the morning and afternoon; one for each wing. A support registered nurse works across both wings, and provides support for the management team and registered nurses and works Monday to Wednesday one week and Monday to Thursday the following week.</p> <p>Inglis wing includes 27 hospital and 1 rest home residents</p> <p>Argyle wing includes 23 hospital and 5 rest home residents.</p> <p>Each wing has five HCAs each morning shift, with one HCA floating between the two wings. The Argyle wing in the afternoon, has two long shifts and two short shifts, while Inglis wing has two long shifts and three short shifts in the afternoons. At night, there is one registered nurse on duty overnight with two HCAs across both wings.</p> <p>The clinical manager (registered nurse) works 72 hours per fortnight Monday – Friday. The facility manager is also a registered nurse and works full time Monday – Friday. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents. Staff interviewed, reported concerns with staffing levels at times, but felt they had enough staff on the day of the audit due to current vacancies.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	<p>FA</p>	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. The service uses the yellow envelope system for all hospital transfers. There are documented</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The discharge process for respite residents includes a process to ensure medications are returned to the resident on discharge</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs who administer medications complete annual medication competencies. Annual in-service education on medication is provided by the supplying pharmacist. Medications (robotic rolls) are checked on delivery against the medication chart and any discrepancies fed back to the pharmacy. All medications are stored safely in two medication rooms. Standing orders are in use, however eight of the twelve GP signed directives were not dated. One self-medicating resident had a self-medication competency completed and reviewed three monthly by the GP. The medication fridge temperature has not been monitored daily as per policy. All eye drops were dated on opening. Controlled drug administration is documented in a register, however the time of administration was not always documented in the register.</p> <p>Ten electronic medication charts were reviewed including one respite admission. All medication charts (except the respite admission) had photo identification and all charts included an allergy status. The GP reviews the medication charts at least three monthly. The administration signing sheets reviewed, identified not all medications had been signed as administered as prescribed. The previous partial attainment continues to require addressing. Prescribed 'as required' medications did not all include the indication for use. The doses and time given is signed for on the administration signing sheet. The effectiveness of pain relief is documented in the electronic medication system and in progress notes.</p> <p>The service has implemented a new process for the management of medications for respite residents. A respite admission file confirmed the new process had been followed, however the file reviewed identified 'as required' medications did not include indications for use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>	<p>FA</p>	<p>Mossbrae Healthcare has a contract with an external catering company to provide all meals. All meals and baking are done off-site and delivered to the service in hot boxes. The external contractor is responsible for the operations of the food services including recruitment, rosters and training. A food control plan has been verified in June 2018. Staff have completed food safety training. The four-weekly seasonal menus have been reviewed by the dietitian. Registered nurses or enrolled nurses complete the nutrition profile which includes: likes and dislikes of the resident, and other special requests such as special diet requirements. This is faxed to the kitchen and alternatives are sent</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>accordingly. There is a whiteboard in the serving kitchen with resident's special dietary profiles. This can be viewed only by the kitchen staff. Special diets being catered for include: pureed and soft diets. Dietary requirements around ethnicities and religious needs are supported. Dislikes and food allergies are known and accommodated. There is a kitchen in both wings and meals are served from the bain marie in the kitchen to residents in the dining room and in resident rooms. There is specialised crockery and cutlery for use as required.</p> <p>The temperatures of refrigerators, chillers, freezers and end-cooked foods are monitored and recorded daily. All food is stored appropriately. A cleaning schedule is maintained. The previous partial attainment has been addressed. Residents have the opportunity to provide feedback at resident meetings and surveys. Residents interviewed had mixed comments on the meals.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The interRAI assessment tool and paper-based assessments are being utilised for assessments and outcomes and are reflected into the long-term care plans. Residents' long-term care plans reviewed were resident-focused and individualised. Care plans documented supports/needs to reflect the resident's current health status, however not all care plans included interventions to support all assessed needs. The previous partial attainment continues to require addressing. Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Care plans are reviewed six monthly or sooner and updated to reflect changes to supports/needs.</p> <p>Short-term care plans were sighted for short-term needs such as weight loss, wounds etc and these were either resolved or transferred to the long-term care plan.</p> <p>There was evidence of allied healthcare professionals involved in the care of the resident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to), accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the contact with family member record page held within the resident file.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan (includes dressing type and evaluations on change of dressings) were in place for two skin tears, five ulcers and one stage two pressure injury. There is access to a wound nurse specialist and district nurses for advice on wound management. Vascular clinic and nurse specialists have been involved in ulcer management. Wound management did not always follow the management plans and assessments were not always fully completed. The previous partial attainment continues to require addressing.</p> <p>Continence products are available. The residents' files included a urinary continence assessment, bowel</p>

		<p>management plan, and continence products used.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose and nutritional intake. Reassessment of residents using restraint or enablers is required by policy to occur at least six monthly, however this did not always occur.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities coordinator is a qualified diversional therapist who has been working in this role for over twenty years. She is supported by a second activities coordinator who is new to the role and works five hours per day; Monday to Friday. The diversional therapist has a current first aid certificate.</p> <p>A resident life history, activity assessment and activity plan is developed soon after admission in consultation with the resident/family and reviewed six monthly in line with the resident's care plan review/evaluation.</p> <p>There is a monthly programme developed with input and suggestions from residents provided via the residents monthly meeting. The programme includes integrated group activities such as entertainment, canine therapy and outings. Mossbrae Healthcare has its own van for transportation, which is used to access events in the community and those occurring at other local aged care facilities. There is a variety of activities that meets the abilities of all residents and to meet the physical, intellectual, sensory and social needs of the residents. Individual one-on-one time is spent with residents who choose not to join in group activity or are unable to participate in activities. Special events and festivities are celebrated, and families are invited to attend.</p> <p>The monthly programme is displayed on noticeboards in each wing. Activities planned for the day are displayed on noticeboards around the facility. Activities occur in the conservatory and lounge areas. Residents and families have the opportunity to feedback on the activity programme through meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Care plans had been evaluated and were current for three of the five resident files reviewed, however not all ongoing evaluations had occurred six monthly (link 1.3.3.3). Two residents had not been at the service six months. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Short-term care plans reviewed had been evaluated at regular intervals. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	FA	<p>The building displays a current warrant of fitness which expires in 10 June 2019. The facility employs a full-time maintenance person. There are proactive and reactive maintenance management plans in place. There is continued refurbishment of resident rooms as they are vacated. Residents have adequate internal space to meet</p>

provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		their needs. External areas are safe and well maintained. The facility van has a current warrant of fitness.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control coordinator/RN oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are discussed at the combined quality/health and safety and infection control meetings. Results from laboratory tests are available monthly. There has been one gastrointestinal outbreak in February 2018. The outbreak was managed appropriately, and notifications made to Public Health.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a restraint minimisation and safe practice policy that is applicable to the service and has recently been updated by the organisation. There are currently four residents using restraint (bedrails and lapbelt) and seven residents using enablers (one wheelchair seatbelt, and all others are bedrails). The enabler consent is in place for the residents using an enabler. Enablers are voluntary. Two resident files reviewed had completed documentation relating to assessments, monitoring and review of enablers, however not all risks associated with the use of the enablers are documented in the long-term care plan (link 1.3.5.2). Monitoring is occurring in line with the instruction on the care plans. Restraint/enabler training has been provided in June 2018.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The files reviewed have a completed assessment form that reflects risk, and when monitoring timeframes, however, care plans do not document the risks associated to minimise the risk of harm to the resident (link 1.3.5.2). Monitoring forms document when monitoring has occurred on an hourly basis as per the assessment form. This is an improvement on the previous audit.

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	The clinical nurse manager is responsible for collecting adverse event data and implementation of the internal audit programme, as per the internal audit schedule. Survey data is collected, and corrective plans documented, but there is little documented evidence to support that this data is being communicated to staff.	There is no documented evidence of discussion of survey results and related corrective actions discussed at staff meetings	<p>Ensure staff are informed of survey results and corrective actions</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	The general manager confirmed reference checks are performed, however these are verbal only and not formally documented.	Reference checks are verbal but not documented.	Document reference checks and keep on file.

				90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	There are education sessions held and competencies are completed by staff such as chemical training, medication, moving and handling and restraint. Health & Disability and code of rights training was last provided in February 2018 with attendance of seven staff (link 1.1.13). However not all compulsory education sessions have been planned for or provided in the last two years.	The service has not provided training around falls prevention, abuse and neglect, culture, pressure injury prevention, challenging behaviours in the last two years. An education session is planned for the end of the year.	<p>Ensure all compulsory education is provided.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	Regular medications are prescribed correctly. Seven of ten charts with 'as required' medications reviewed included the indication for use prescribed on the medication chart. Medication charts have been reviewed by the GP three monthly. The pharmacist completes a weekly stocktake of medications with the RN. Gaps were identified in medication signing sheets. Medication storage fridges were monitored, but not daily as required.	<p>i) Eight of twelve GP standing orders were not dated.</p> <p>ii) Two of ten medication signing sheets identified that medication has not always been signed as administered.</p> <p>iii) Three of ten 'as required' medications did not include the reason for administration (including the respite file).</p> <p>iv) The temperature of the medication fridges is not consistently documented.</p> <p>v) The controlled drug register did not include the time of administration for four entries.</p> <p>vi) The assessment of the</p>	<p>i) Ensure standing orders are reviewed, signed and dated annually.</p> <p>ii) Ensure medication signing sheets document the administration of prescribed medications.</p> <p>iii) Ensure all 'as required' medications include a reason for administration.</p> <p>iv) Document medication</p>

			one self-medicating resident had not been reviewed six monthly.	fridge temperatures daily as per policy. v) Ensure the controlled drug register includes the time of administration. vi) Ensure self-medicating residents are assessed for competency six-monthly as per policy. 30 days
<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>	<p>PA Moderate</p>	<p>The RNs are responsible for completing the initial assessment and initial care plans on admission, however the respite resident did not have these documented within contractual timeframes (also link 1.1.13). All files reviewed had current interRAI assessments and long-term care plans but not all ongoing assessments and evaluations had been completed six monthly.</p>	<p>i) An initial assessment and care plan were not completed for the respite resident within required timeframes.</p> <p>ii) Ongoing interRAI assessments were not completed six monthly for three of four long-term residents.</p> <p>iii) Evaluations have not always been completed six monthly.</p>	<p>i) Ensure all initial assessments are completed within 24 hours and initial care plans within 48 hours of admission.</p> <p>ii) Ensure interRAI assessments are reviewed at least six</p>

				<p>monthly or sooner for changes in health.</p> <p>iii) Ensure long-term care plans are evaluated six monthly.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA</p> <p>Moderate</p>	<p>All five resident files reviewed have a care plan in place, and staff are aware of care needs for all residents (also link 1.1.13). However, not all care plans included interventions to support all assessed needs.</p>	<p>(i) Two residents (one hospital and one RH) with a history of falls did not include all interventions or strategies required to minimise the risk.</p> <p>(ii) One hospital respite resident with pain did not include interventions to manage all aspects of pain relief.</p> <p>(iii) One hospital resident with weight loss did not have interventions documented to support nutritional needs.</p> <p>(iv) One hospital resident using an enabler (bedrails) did not document the associated risks.</p>	<p>(i) – (iv) Ensure that long-term care plans include interventions to manage and support all assessed needs.</p> <p>60 days</p>

<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Individual wound assessment, treatment and evaluations are completed for seven of eight wounds. Three of eight wound assessments, wound management plans and evaluations reviewed are fully completed and follow the management plan.</p>	<p>(i) Three of eight wound assessment, treatment and evaluation forms do not document achievement towards the wound healing process with each dressing change.</p> <p>(ii) Five of eight wound were not redressed at the documented frequency.</p> <p>iii) One resident using an enabler had not been reviewed six monthly.</p>	<p>(i) Ensure the plan for each wound monitors progress towards the wound healing process.</p> <p>(ii) Ensure all wounds are redressed at the frequency documented on the wound management plan.</p> <p>iii) Ensure all residents using enablers or restraint are reviewed at least six monthly.</p> <p>60 days</p>
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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.