

Lester Heights Hospital Limited - Lester Heights Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Lester Heights Hospital Limited
Premises audited:	Lester Heights Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 27 February 2019 End date: 28 February 2019
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:	26

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lester Heights has been owned and managed by the owner for two and a half years. The service is certified for rest home, hospital and residential disability – physical levels of care. On the day of the audit there were a total of 26 residents living at the facility across their 35 certified beds.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The owner manager is an experienced manager and works full time. An experienced clinical manager and lead registered nurse provide day to day clinical management.

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

Two of the two shortfalls identified as part of the previous audit have been addressed. These were around family communication post incident and the signing of medications.

This audit has identified three areas requiring improvement around; timeliness of assessments, care planning and activities.

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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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is a business plan with goals for the service that has been regularly reviewed. Lester Heights has a fully implemented, quality and risk system in place. There is a business plan with goals for the service that has been regularly reviewed. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

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

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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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. An activity plan is documented. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness. There are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. There is safe access to the communal areas and outdoor seating and shade.

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 service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints and five with an enabler at the time of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	1	0	0
Criteria	0	40	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written, is maintained by the facility manager using a complaints register. There have been ten complaints made in for 2018 and one in 2019 year to date. All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. One complaint was via the Health and Disability advocacy service, this complaint has been followed up and closed to the satisfaction of the complainant and the advocacy service.</p> <p>Residents (two rest home and three hospital and one younger person, also hospital level) and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p> <p>One anonymous complaint to the DHB was reviewed. This was reviewed by the DHB at the time and an action plan implemented around areas that were substantiated.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The assistant manager and clinical manager confirmed family are kept informed. Relatives (two hospital) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents and this is an improvement from the previous audit. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required. The communication needs of younger residents are addressed, including a resident who is unable to hear. This resident is able to lip read but also has a communication board to assist if 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>Lester Heights has been owned and managed by the owner and his wife for two and a half years. An experienced clinical manager and a registered nurse lead provide day-to-day clinical management. The service is certified for rest home, hospital and residential disability – physical levels of care. All 35 beds at Lester Heights are certified for dual-purpose. On the days of the audit, there were a total of 26 residents living at the facility. There were six residents receiving rest home level care, including one funded under a long-term support - chronic health conditions (LTS-CHC) contract and two funded under a mental health contract. There were 20 residents receiving hospital level of care including one respite resident (a younger person), one funded under a mental health contract and nine permanent residents funded under a ministry disability contract.</p> <p>A current business plan has been developed with specific goals around reducing skin tears, urinary tract infection, pressure injuries and medication errors. The plan identified the purpose, values, scope and direction of Lester Heights. The plan also includes specific goals to ensure the needs of younger people in the service are met.</p> <p>The owner/manager has received ongoing mentoring and professional development related to managing an aged care facility since the last audit, from the quality/clinical consultant.</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>FA</p>	<p>Lester heights has an established quality and risk programme. A complete new set of policies and procedures (and clinical documentation) have been developed by the quality/clinical consultant. These include a number of policies specific to younger people residing in an aged residential care environment and align with current good practice and meet legislative requirements.</p> <p>Staff (three caregivers, one lead registered nurse, one cook, and one activities person and two RN CAPs students) confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support hospital level care.</p> <p>Monthly quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs.</p>

improvement principles.		<p>Facility meetings held include: monthly staff/quality meetings, quarterly service reviews of quality goals, and monthly RN meetings. Meetings minutes sighted evidenced there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and corrective actions. Registered nurse meetings also document review of clinical issues, resident care and care planning.</p> <p>There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Audit outcomes are tabled and discussed at the monthly staff/quality meetings. There is evidence of audit follow-up, action plans and sign off when completed.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. A senior caregiver leads health and safety. Education, internal audits and non-clinical accident/incident investigation are included as part of the clinical manager and assistant managers role. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>An annual resident/family survey is undertaken, and issues raised have been followed up. This includes increasing housekeeper hours, management of maintenance issues, resident outings and afternoon high teas.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</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>The service collects incident and accident data on forms and enters them into an electronic register. The system provides reports monthly, which are discussed at the monthly staff/quality meetings.</p> <p>The service demonstrated robust incident and accident follow-up; this has included medication errors investigated in association with the pharmacy, with pharmacy signing off that all issues had been rectified. Staff/quality meetings also document that each incident is discussed with staff as well as follow-up. Each month the clinical manager reviews all incidents on the log and reviews each incident to ensure that care plans are updated, and any issues rectified.</p> <p>Five incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents.</p> <p>The facility manager interviewed could describe situations that would require reporting to relevant authorities. The service has reported two missing resident reports and three pressure injuries to the Ministry of Health.</p>
Standard 1.2.7:	FA	There are policies to support recruitment practices. The register of RNs practising certificates and allied health

<p>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>professionals is current. Five staff files were reviewed (one RN, three caregivers and one cook). All files contained relevant employment documentation including current performance appraisals and completed orientations. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care.</p> <p>Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is an annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. The programme included training, following issues raised though audit, incidents or for new admissions. This has included caring for a deaf resident, shingles management, and additional medication training following medication errors. Staff received comprehensive training around meeting the varied needs of younger people living in an aged residential care environment in July 2017 and this is planned to be repeated.</p> <p>Three of six RNs have completed their interRAI training. Clinical staff complete competencies relevant to their role. The RNs and clinical manager have completed syringe driver training and have access to external 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 an organisational staffing policy that continues to align with contractual requirements and includes skill mixes.</p> <p>One RN is on duty 24 hours a day, seven days a week. This includes either the clinical manager or the registered nurse lead on morning shift. The clinical manager has three days and the registered nurse lead has two days when they are not on the floor and undertake quality activities.</p> <p>The healthcare assistant roster is as follows: for 26 residents (6 rest home, 20 hospital).</p> <p>AM shift: One healthcare assistant full shift, one 07.00 am to 1.00 pm, and one 07.00 am to 10.00 am (this shift can be made longer depending on need).</p> <p>PM shift: One healthcare assistant full shift, two 3.00 pm to 6.00 pm and one 3.00 pm to 9.00 pm.</p> <p>Night shift: One healthcare assistant.</p> <p>Staffing is flexible to meet the acuity and needs of the residents. Interviews with staff, residents and families confirmed staffing overall was satisfactory.</p>
<p>Standard 1.3.12: Medicine Management</p>	<p>FA</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual electronic medication orders with photo identification and allergy status documented. The service uses a four-weekly roll pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Administration sheets sampled were appropriately signed, this is an improvement from the previous audit. Nine electronic medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. The respite resident had a paper-based prescription chart. A registered nurse was observed administering medications and followed correct procedures. One resident self-administers eye drops and had current competency assessments around this. They have access to secure storage in their rooms. Staff check each shift that these residents have safely self-administered their medications and record this on the medication administration sheet.</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>All meals at Lester Heights are prepared and cooked on-site by a qualified cook.</p> <p>All staff have attended food safety and hygiene training. The service accommodates cultural food preferences for Māori with Māori dishes provided on the menu. The service caters for other cultures upon request. The cook interviewed was knowledgeable about resident dietary requirements and receives a resident dietary profile and any likes or dislikes. Special diets including modified foods are provided, including morning tea (cakes are moistened and mashed for instance for residents needing a soft/puree diet).</p> <p>There is a documented dietitian review of the menu (May 2017). The food control plan was verified June 2018.</p> <p>Staff were observed assisting residents with their meals and drinks at lunchtime. A smaller dining room/lounge is used to maintain the dignity of residents requiring additional assistance. Special equipment is available and was observed in use.</p> <p>Fridge, freezer and end-cooked temperatures (sighted) are monitored daily. A kitchen cleaning schedule is in place and implemented. The kitchen was observed to be clean and there was a food rotation system in place.</p> <p>Chemicals are stored safely within the kitchen. The manager and assistant manager have access to the bulk food store. And all food stuff was stored appropriately. The manager and cook confirmed that all meals are cooked using fresh ingredients as much as possible with the cook providing a shopping list for the manager.</p> <p>Resident meetings and surveys, along with direct input from residents, provides resident feedback on the meals and food services. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>The kitchen has been improved with a new freezer and improved food storage. Food stocks have been increased to ensure there is always two weeks meals available if needed.</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>FA</p>	<p>Click here to enter text</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 Low</p>	<p>Care plans sampled were goal orientated, however all interventions were not documented on the care plan and/or documented as implemented. The staff interviewed stated that they have sufficient equipment and supplies to provide care. The owner has improved access to equipment by allowing the clinical manager to order some equipment as needed.</p> <p>The respite resident had an age appropriate care plan in place that lacked activities (1.3.7.2). One rest home resident funded through mental health services for older people included mental health input to care and a documented routine for smoking and management of behaviours that challenge. Weight loss was managed well in the care plan and the cook was able to explain how they manage additional snacks and meals, but weights had not always been documented as per care plan.</p> <p>There were nine residents with wounds at the time of the audit. One resident had a healing grade 2 pressure injury. The service has wound care templates for chronic wounds and a template for more short-term wounds. The chronic wounds included assessments, management plans and documented reviews. Shorter term wounds lack a formal assessment process and plan of care.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist commenced at the service on day two of the audit to assist with mobility assessments and the exercise programme.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</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</p>	<p>PA Moderate</p>	<p>The service has very recently employed a new activities person, she was previously employed by the service and frequently used to assist the departing activities staff member. The activities person works five days a week and is being assisted in her role by the assistant manager (also an experienced staff member).</p> <p>Group activities are provided in the large communal dining room/lounge; however, the activities plan consists of bowls, bingo and darts every week. Residents, relatives and staff informed that these have been the only activities available. The new activities person discussed new plans for a wide range of activities including activities for the younger residents.</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>The activity person with the lead RN interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop an activity plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. Participation in all activities is voluntary.</p> <p>The service hires a van to take residents out. The last resident survey reported they wanted extra outings (planned and actioned), and some changes around afternoon tea times (time changed to slightly later as requested and communication to staff seen through the staff meeting minutes).</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>Residents have a documented evaluation of care six-monthly. This does not always align to the interRAI process (link 1.3.3.3). Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The lead registered nurse interviewed, explained the communication process with the GP. Short-term care plans were evident for most of the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required (link 1.3.6.1).</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>The building has a current building warrant of fitness that expires 1 December 2019.</p> <p>The owner is the maintenance person and ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. There is a planned (sighted) maintenance repair list the maintenance person is working through. There is an ongoing refurbishment/refresher of bedrooms as they become vacant. A carpet replacement plan is in progress and there has been some landscaping of gardens. New beds have been purchased as part of an ongoing replacement programme, security cameras have been installed. Other improvements have included a new sanitiser.</p> <p>Monthly inspections include call bell testing, monthly fire checks and hot water temperature monitoring. Temperature recordings reviewed were between 43-45 degrees Celsius. Essential contractors are available 24-hours. Electrical test and tag checks on all facility and resident electrical equipment had been completed August 2017.</p> <p>Annual calibration and functional checks of medical equipment is completed by an external contractor. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas. Seating and shade is provided. There is a designated outdoor smoking area.</p> <p>The RNs and HCAs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the</p>

		<p>resident care plans including hoists and pressure injury prevention equipment.</p> <p>Younger residents have rooms throughout the facility and share the same communal areas as other residents. Those interviewed felt this was satisfactory.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints and five with enablers at the time of the audit. One care plan for a resident with a bedrail enabler included and assessment, consent, care plan interventions, monitoring as per the care plan and three-monthly reviews of the enabler.</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 1.3.3.3</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 Low	<p>The four long-term residents all had an up-to-date interRAI assessment that linked to the care plans. Care had been evaluated six monthly but not aligned to the same timeframe as interRAI assessments. A new resident under the ARCC contract did not have a new interRAI within timeframes. However, the long-term care plan had been developed within timeframes and interRAI information added later. The service has also commenced a process to address the timeframes for new resident interRAI assessments.</p>	<p>(i)The first interRAI was not within timeframes for one new rest home level resident. The LTCP had been completed prior to the first interRAI assessment. (ii) Evaluations of care were not aligned to the interRAI for one hospital and two rest home residents.</p>	<p>(i)-(ii) Fully implement the process for interRAI timeframes and link to timeframes for new long-term care plans and evaluations of care plans.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p>	PA Low	<p>All residents had a care plan documented that reflected the interRAI assessment. Care needs identified through progress</p>	<p>(i). One rest home resident did not have interventions for</p>	<p>(i)-(ii). Ensure that care plans</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>notes, and ongoing resident review such as special diets and wound care were not always reflected into the care plan. Not all weights had been documented as per plan. All residents with wounds had a wound care plan in place, but not all wounds had a formal assessment and management plan documented.</p>	<p>high falls risk. (ii) –(iii). One rest home resident did not have the need for a low sodium diet documented in the kitchen, (although the cook was aware) and two weekly weights had not always been documented as per GP instruction. (iv). Acute care plans did not have a formal holistic assessment of the wound and a management plan documented.</p>	<p>reflected clinical needs and that all associated services have documentation regarding resident needs. (iii). Ensure that weights are documented as per instruction. (iv). Ensure that all wounds have a process documented that includes a formal assessment and management plan.</p> <p>90 days</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Moderate</p>	<p>The newly appointed activity staff member has recognised that the current activity plan for the service does not provide a range of activities for the resident group. She has linked to an online activity group and has researched activities for the service. An exercise programme has been commenced.</p>	<p>The service activity plan does not provide a range of activities to suit all residents including those with higher needs, and younger residents.</p>	<p>Ensure that there is an activity programme in place that provides meaningful activities for the wide range of residents at the service.</p>

				30 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.