

# Bucklands Beach Rest Home Limited - Bucklands Beach Rest Home

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Bucklands Beach Resthome Limited
<b>Premises audited:</b>	Bucklands Beach Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 March 2019 End date: 13 March 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	16

# Executive summary of the audit

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## 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

Bucklands Beach Rest Home can provide rest home level care for up to 20 residents. On the day of the audit there were 16 residents.

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

The owner/manager is the RN. She has been operating this facility for 20 years. The manager has maintained a minimum of eight hours of professional development relating to the management of an aged care facility.

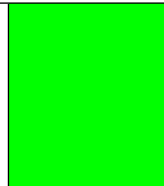
The service has an established quality and risk management system. Residents, family and the general practitioner interviewed, commented positively on the standard of care and services provided.

One of the three shortfalls identified as part of the previous audit have been addressed. This was around access to call bells. There continues to be improvements required around medication management and self-medicating.

This audit has identified further areas requiring improvement around; incidents and accidents, assessments, and implementation of care and fire drills.

## 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.

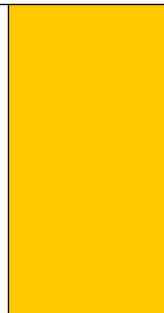


Standards applicable to this service fully attained.

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.



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

There is a business plan with goals for the service that has been regularly reviewed. Bucklands Beach Rest homes has a fully implemented quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys.

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.

## 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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Care plans are developed by the registered nurse who also maintains and reviews 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. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activities therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents reported satisfaction with the food service.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There is a current building warrant of fitness.

## Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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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 or enablers at the time of the audit.

## 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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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	1	4	0	0
Criteria	0	43	0	1	5	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints' register. There have been three complaints made for 2018 and 2019 (YTD), this includes two Health and Disability complaints. One Health and Disability complaint has now been closed with suggestions for improvement from the Health and Disability service.</p> <p>One Health and Disability complaint was received in February and the service has recently sent information as requested. The DHB is aware of both complaints. Five residents and a family member interviewed advised that they are aware of the complaint procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p> <p>The Ministry requested follow up against aspects of a complaint that included training, pain and wound care assessment and management, care planning and referral to specialists. This audit has identified issues around the management of wounds by caregivers, wound assessment and wound management plans and registered nurse follow-up of issues raised (link 1.3.6.1). Pain assessments also continue to be a shortfall (link 1.3.4.2). Training has been provided around pain management and wound care.</p>
Standard 1.1.9:	FA	The open disclosure policy is based on the principle that residents and their families have a right to know what



<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>has happened to them and to be fully informed at all times. The care staff interviewed (nurse manager, three caregivers and a cook) understood about open disclosure and providing appropriate information when required. The nurse manager confirmed family are kept informed. One relative interviewed 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 the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents.</p> <p>An interpreter service is available and accessible if required through the district health board.</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>	FA	<p>Buckland's Beach Rest Home is owned and operated by the registered nurse manager. Buckland's Beach Rest Home can provide rest home level care for up to 20 residents. On the day of the audit there were 16 residents. This included two residents on long-term chronic conditions contracts. All other residents were under the ARCC contract.</p> <p>A philosophy, mission, vision and values is in place. The business and quality plan has been regularly reviewed by the registered nurse manager.</p> <p>The nurse manager has a current practising certificate and works full time. She has been operating this facility for 20 years. The manager has maintained a minimum of eight hours of professional development relating to the management of 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 improvement principles.</p>	FA	<p>The quality and risk system implemented at Buckland's Beach Rest Home has been developed by an aged care consultant. There are regular policy and procedure updates as needed and these are communicated to staff.</p> <p>Policies and procedures are implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>Two-monthly staff 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 (link to 1.2.4.3). Monthly comparisons include detailed trend analysis and graphs.</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. Corrective actions are developed, implemented and signed off.</p>

		<p>There is an implemented health and safety and risk management system in place including policies to guide practice. The nurse manager is responsible for all aspects of health and safety with assistance from a designated caregiver. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has 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>	<p>PA Moderate</p>	<p>The service collects incident and accident data on forms and enters them into a paper-based register. Reports are generated monthly by the nurse manager, which are discussed at the staff meetings.</p> <p>There were five incidents recorded for January; three falls, one medication error and one resident behaviour issues. Not all incidents had an incident form completed. Incident forms identified a timely RN assessment of the resident. Neurological observations were not completed for unwitnessed falls and any known head injury and RN follow-up to ensure continued safety was not well documented (link 1.3.6.1). The next of kin had been notified for all required incidents/accidents. The caregivers interviewed could discuss the incident reporting process.</p> <p>The nurse manager interviewed could describe situations that would require reporting to relevant authorities. There have been no reports needed.</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>There are human resources policies to support recruitment practices. The register of RNs' practising certificates and allied health professionals is current. Five staff files were reviewed (three caregivers, one housekeeper and one cook). All files contained relevant employment documentation including current performance appraisals and completed orientations. A current practising certificate was sighted for the registered nurse manager. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. 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. Pain and wound care management have been provided by the nurse practitioner from the DHB with 100% attendance. Skin and pressure injury care, documentation, have also been provided (as well as other compulsory subjects). The nurse manager has completed interRAI training. Care staff complete competencies relevant to their role.</p> <p>Care staff interviewed were able to discuss the on-call process and there was a direction chart on the wall of</p>

		the nurses' station with on call and emergency calls process.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy aligns with contractual requirements. The nurse manager is on-site four days a week and is on call when not available on-site 24/7. A casual RN covers when she is on leave.</p> <p>There are adequate numbers of caregivers available with one caregiver rostered during the night shift and two caregivers (one long shift and one short shift) rostered on the am and pm shifts. An activities therapist is available five days a week (9.00 am – 1.00 pm). Staffing is flexible to meet the acuity and needs of the residents.</p> <p>A separate cleaner is employed four days a week. Caregivers are responsible for laundry duties. They also assist with breakfast and supper, with direction provided by the cook.</p> <p>Interviews with residents and a family member confirmed staffing overall was satisfactory. Staff stated they feel supported by the nurse manager who responds quickly to after-hour calls. The GP confirmed that he is called in a timely manner.</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>	PA Moderate	<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 medication orders with photo identification and allergy status documented.</p> <p>The service uses a four-weekly roll pack system for tablets and other medicines are pharmacy packaged. A verification 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. There is a dedicated fridge for medications, this is an improvement from the previous audit.</p> <p>Education on medication management has occurred with competencies conducted for the caregivers with medication administration responsibilities. Administration sheets sampled were not always appropriately signed. Ten medication charts reviewed identified that the GP had seen the resident three-monthly. Not all medication given was prescribed, short course medication did not always have a stop date. A caregiver was observed administering medications and followed correct procedures.</p> <p>There were no residents who self-administered medications, but one resident who had self-administered previously (and it was unclear if they still did), still stored the insulin in his room. This medication was not stored securely and the resident, had a recent hypoglycaemic episode due to incorrect administration of insulin. The management and storage of self-administered medication is a repeat shortfall.</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 food is cooked on-site. The service has cooks who cover Monday to Friday. The head cook oversees the procurement of the food and management of the kitchen. There is a well-equipped kitchen. Meals are served directly from the kitchen to the dining rooms via a hatch. Special equipment such as lipped plates are available if required. The food control plan is in the process of verification.</p> <p>On the day of audit meals were observed to be hot and well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded weekly. Food temperatures are checked, and these were all within safe limits.</p> <p>The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on a kitchen whiteboard. The four-weekly menu cycle is approved by a dietitian. All resident/families interviewed were very satisfied with the meals.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Files sampled contained interRAI assessment tools that were complete and reviewed at least six-monthly. The interRAI assessment tool is implemented. InterRAI assessments had been completed for residents whose files were sampled.</p> <p>Resident with ongoing assessment needs outside of the interRAI process did not always have this documented.</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>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. All care plans are resident centred. Residents and relatives interviewed stated that they were involved in the care planning process. There was evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, wound care specialist and mental health care team for older people. The care staff interviewed advised that the care plans were easy to follow, and guidelines were clear.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive</p>	<p>PA Moderate</p>	<p>Care plans sampled were goal orientated and they had been evaluated and updated by the RN manager at least six monthly. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.</p>

<p>adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>The care was observed to be supportive and caring on the day of audit.</p> <p>There were three wounds at the time of the audit. There were no residents with pressure injuries. All three wounds had an assessment, and documented reviews, however ongoing assessment of the wounds was undertaken by caregivers and one wound did not have a fully developed management plan. Two wounds were deteriorating but there was no documented specialist/GP review, and this was actioned on the day of audit.</p> <p>There is an RN available, four to five days a week (the nurse manager) who develops and reviews all resident care plans, however RN input to care and follow-up is not documented post falls and no GP review was documented for a resident post hypoglycaemic episode.</p> <p>Advice is available from the DHB as needed. A physiotherapist is available as needed.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is one activities therapist who works four hours daily, five days a week. On the day of audit residents were observed participating in exercises, making flower pot art and listening to music.</p> <p>There is a weekly programme. The daily programme is written up on a whiteboard in the dining room. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, brain teasers, news from the NZ Herald, music, walks outside and games.</p> <p>Those residents who prefer to stay in their room or who need individual attention, have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>Church services are held three-weekly and Catholics have communion weekly.</p> <p>There are weekly van outings and entertainers visit the facility and there is community input from local kindergartens and schools. Special events like birthdays, Easter, Mothers' Day, Anzac Day and the Melbourne Cup are celebrated.</p> <p>There is a men's group which has outings six-weekly including lunches at the RSA and the movies.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly.</p> <p>Resident meetings are held two monthly.</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 are reassessed using the interRAI process at least six-monthly. Long-term care plans are then evaluated and rewritten. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews are signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (link 1.3.6.1). The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if 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>The building holds a current warrant of fitness which expires 8 June 2019. There is no maintenance person on-site but the manager phones contractors when maintenance is required.</p> <p>Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range.</p> <p>The communal lounges and hallways are carpeted as are residents' bedrooms. The utility areas such as the kitchen, laundry/sluice rooms have vinyl flooring. Toilets and showers have non-slip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Staff interviewed stated that there is equipment available to meet all resident needs including wheelchairs and walking frames.</p> <p>Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. All outdoor areas have some seating and shade. There is safe access to all communal areas. Mobility scooters are parked under cover in an outside porch.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>PA Low</p>	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. The orientation programme and annual education and training programme includes fire and security training; however, fire evacuations training/practice has not been in place since April 2018. Staff interviewed confirmed their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>A civil defence plan is documented for the service. There are adequate supplies available in the event of a civil defence emergency including food, water, and blankets. A gas cooker is available.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Call bells are checked regularly by maintenance. All showers have an accessible call bell; this is an improvement from the previous audit.</p> <p>There is a minimum of one staff member available 24 hours a day, seven days a week with a current first aid/CPR certificate.</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 or enablers at the time of the audit.</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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>The service has an incident process in place and incidents and accidents were evidenced to be documented for incidents such as falls, resident altercations and some medication related incidents (incorrect medication given). Not all events are registered as an incident and not all have a subsequent investigation undertaken.</p>	<p>Interview with a resident and review of progress notes evidenced a hypoglycaemic episode may have been caused by a malfunctioning insulin pen and repeated attempts to make it work. The hypoglycaemic episode was successfully treated, and ongoing blood sugar level undertaken to ensure the full recovery of the resident. It was not clear if a GP was informed (link 1.3.6.1 and 1.3.12.5). There was no incident form for this or evidence of an investigation and strategies to minimise any future risk.</p>	<p>Ensure that an incident form is documented for all incidents and accidents and that investigation is undertaken.</p> <p>30 days</p>



<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>There is a robust policy and associated procedures in place to safely manage the medication system. Not all procedures have been implemented into practice.</p>	<p>(i). One resident stored his insulin pen in his room, the storage is not secure.</p> <p>(ii) One resident has been administered as needed paracetamol medications since 18 February with no prescription.</p> <p>(iii) One short course medication had no stop date.</p> <p>(iv) Two residents with controlled drug medication did not have two signatures for all controlled drug medications given on the administration chart.</p>	<p>(i) Ensure that all medication is stored securely.</p> <p>(ii) Ensure that all medication is prescribed.</p> <p>(iii) Ensure all medication is prescribed appropriately.</p> <p>(iv) Ensure there are two signatures for controlled drug medication administration.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>There are policies and procedures for safe self-medication. There are forms available for assessment of competency and consent where appropriate. One resident no longer self-medicated (however this was unclear), but there was evidence that on occasions he administered insulin. This resident also continued to store his insulin in his room and had recently had too much insulin possibly due to a pen malfunction or poor technique. This issue has not yet been investigated (link 1.2.4.3). This resident did not have documented evidence of his</p>	<p>One self-medicating resident has not been assessed as competent to self-medicate. The same resident has not signed a consent form for self-medication.</p>	<p>Ensure residents who wish to self-medicate are assessed as competent to do so. Ensure residents who wish to self-medicate sign a consent form for self-medication.</p> <p>30 days</p>

		competency assessed to self-medicate.		
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Moderate</p>	<p>The interRAI process has been fully implemented by the service. There is evidence of paper-based assessments such as behaviour assessments documented. Pain assessment and the ongoing assessment of wounds is not well documented.</p>	<p>(1) Pain assessments are not consistently documented for residents with identified pain needs; (i) one resident who has pain did not have a formal pain assessment since January; (ii) one resident with identified back pain has informal pain assessment from caregivers through progress notes but no RN assessment, and (iii) one resident who presents with behaviours that challenge and has as needed paracetamol daily, had no pain assessment.</p> <p>(2) The assessment of wound does not include photos and regular and ongoing assessment of wounds is not documented by an RN.</p>	<p>(1) -(2) Ensure that there is ongoing and documented assessment of resident needs by a registered nurse.</p> <p>30 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>The service has robust policies in place to guide and support staff including reporting to the RN, wound care, and neurological observation, but these policies are not implemented in practice. All three wounds had and intimal assessment but ongoing assessment and referral when the wounds deteriorated was not evidenced.</p>	<p>(i) Two of three wound care plans did not document ongoing and regular assessment by the RN; (ii) there was no referral to specialist/ GP for wound review has been delayed due to the RN being unaware of changes to the wound status for two wounds; (iii) wound specialists for two wounds have been consulted in the past (one nurse specialist and one plastics department) but there is no documentation from either to guide staff. (iv) One wound did not include cleaning method for the wound. (v) The GP has not been documented as informed for a follow-up review post a hypoglycaemic episode for one resident. (vi) Neurological observations were not documented for two falls related head injuries during January and caregiver or RN follow-up was not documented following the incidents.</p>	<p>(i)-(ii) Ensure that all wounds document ongoing and regular assessment by an RN and there is prompt referral to specialist/GP when deterioration is noted. (iii) Ensure that specialist intervention is documented. (iv) Ensure that wound management plans document all care and support needed. (v) Ensure the GP is informed for acute changes to resident's status. (vi) Ensure neurological observations are</p>

				documented according to policy.  60 days
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Low	<p>Emergency and disaster policies and procedures and a civil defence plan are documented for the service. The orientation programme and annual education and training programme include fire and security training; however, fire evacuations training/practice has not been in place since April 2018.</p>	<p>There has been no fire evacuation drill since April 2018. Since the draft report the provider advised that a fire drill was completed 24/4/19.</p>	<p>Ensure fire evacuations are trialled six monthly.</p> <p>60 days</p>

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

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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
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End of the report.