

Home of St Barnabas Trust - Home of St Barnabas

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: Home of St Barnabas Trust

Premises audited: Home of St Barnabas

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 27 May 2019 End date: 28 May 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: 39

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 |
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|  | 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 |
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| | 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 |
| | 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

The Home of St Barnabas Trust is a charitable trust. The Trust is governed by a Board of Trustees that provide governance and direction. The home provides rest home level care for up to 41 residents. On the day of audit, there were 39 residents.

The service is managed by an experienced manager that has been in the role for more than 20 years. She is supported by the line management team and the trust board. The residents, relatives and general practitioner commented positively on the care and services provided.

This surveillance audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, a family member, staff and management.

The service has addressed six of seven of the previous findings around incident report follow-up, education, progress notes, assessments, minimising risks, and medications. A further improvement is required around care plan interventions.

This audit identified a shortfall around the quality programme.

Consumer rights

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| 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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Home of St Barnabas provides care in a way that focuses on the individual resident. 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

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| 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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Home of St Barnabas has a current business plan, which includes a quality and risk management plan. The quality programme includes monthly analysis of quality data. Quality information is reported to facility meetings. The health and safety programme includes hazard management. Incidents are documented and analysed as part of the quality data in monthly reports. Residents have an opportunity to feedback on service delivery issues at the resident meetings.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education planner in place for 2019 through the online system and is being implemented. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> | | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
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The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Residents the relative interviewed confirmed they were involved in the care plan process and review. Resident files include notes by the general practitioner and allied health professionals. The general practitioner completes an admission assessment, visits and reviews the residents at least three-monthly.

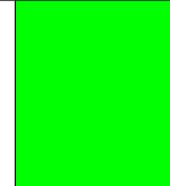
A diversional therapist facilitates the activities programme. The programme is resident-focused and provides group and individual activities planned around everyday activities. Each resident has an individualised plan. Community activities are encouraged, and van outings are arranged on a regular basis.

There are medicine management policies and procedures in place that reflect legislative requirements. Medication is managed using an electronic medication management system. The medication charts are reviewed by the GP three-monthly. All staff responsible for administration of medicines had completed education and medication competencies.

All meals and baking are prepared on site, a dietitian has reviewed the menu. Individual and special dietary needs are accommodated. Residents interviewed responded favourably to the food provided.

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.

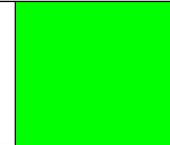


Standards applicable to this service fully attained.

The building is working towards obtaining a current warrant of fitness. The building, plant and equipment comply with legislation. There is a preventative maintenance schedule in place. There are sufficient bathroom facilities to meet the needs of residents. Internal communal areas are spacious and light. External areas are safe and easily accessible for residents and relatives and provide 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.

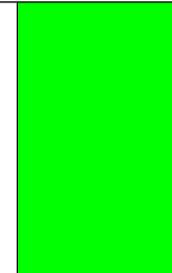


Standards applicable to this service fully attained.

The service is restraint free. There were no residents using enablers at the time of the audit. All staff have received training on restraint minimisation and challenging behaviours.

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.

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. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 16 | 0 | 1 | 1 | 0 | 0 |
| Criteria | 0 | 42 | 0 | 1 | 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 |
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| <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>Complaint forms are available at the main foyer. Staff interviewed were aware of the complaints process and direct complaints to the management or the registered nurse (RN). The complaints process is in a format that is readily understood and accessible to residents and their families. Four residents and one relative interviewed, confirmed that they understand the complaints process.</p> <p>Two minor complaints were documented on the complaint register since the previous audit. Documentation reviewed identified that these were all followed-up and managed appropriately, within timeframes and with acknowledgement and response being documented when completed.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p> | FA | <p>There is an open disclosure policy, complaints policy and incident reporting policy. Ten incident forms reviewed identified that relatives/NOK have been notified for adverse events affecting their family members. Residents' meetings are held three monthly. The service has policies and procedures available for access to interpreter services. Interviews with staff; (three caregivers, one registered nurse (RN) and one diversional therapist [DT]) confirmed knowledge around how to access interpreter services. Four residents interviewed stated all staff and management are approachable. The relative interviewed feels they are well informed of any changes.</p> |

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| communication. | | |
| <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>The Home of St Barnabas Trust was incorporated as a Charitable Trust under the Charitable Trusts Act 1957 in 2003, by the Anglican Diocese of Dunedin. The Trust is governed by a Board of Trustees that provide governance and direction. The home provides rest home level care for up to 41 residents. On the day of audit, there were 39 residents including three residents on respite care, all long-term residents were funded under ARCC.</p> <p>The manager reports monthly to the board of trustees. The quality team includes the manager, the quality manager (RN) the care manager (RN) the kitchen supervisor and the house supervisor (line managers). There are monthly manager and quality meetings held, minutes document discussion of data collated, and trends identified.</p> <p>The facility has a current business plan, which includes a quality and risk management plan. A quality management system includes gathering data and information to provide opportunities for quality improvement.</p> <p>The service is managed by an experienced manager that has been in the role for over 25 years. The manager has completed more than eight hours training related to her current role in the past 12 months. She is supported by line managers, long serving staff and the board of trustees. The manager was on leave during the audit. The kitchen manager is the acting manager.</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> | PA Low | <p>There is a business, quality, and risk management plan that includes aims and ambitions for the year 2019. Progress with the quality and risk management plan is monitored through the monthly management meetings, three monthly quality meetings, and three-monthly general staff meetings. Minutes for meetings included actions to achieve compliance where relevant and these are available for staff to read. Quality meeting minutes include 'plans, aims and ambitions' for quality initiatives, internal and external audits and corrective actions taken, incident and infection data and analysis, restraint, education, health and safety, food services, and a 'from the board' section. Clinical meetings are held two monthly. A review of the meeting minutes showed individual review of resident medical condition, medication reviews, referrals to other health services and current treatment plans.</p> <p>Internal audits were completed as per the internal audit schedule around health and safety, cleaning and laundry, however not all clinical audits have occurred according to the schedule. Any area of non-compliance identified in the audits completed includes the implementation of a corrective action plan with sign-off by the facility manager when it is completed.</p> <p>The house supervisor is the identified health and safety representative and has completed H&S training and attends a H&S forum every year. The hazard manual was last reviewed in November 2018. Hazards are reported on accident and hazard forms and hazard identification forms are taken to the quality meeting to discuss. Contractor management (as part of the health and safety programme) forms have been completed and are kept in the health and safety file. Health and safety is part of the orientation programme and is available online for staff to</p> |

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| | | <p>access. The health and safety representative collates information on resident incidents and accidents as well as staff incidents/accidents, and provides follow-up where required. Forty staff are first aid trained, there is at least two first aiders on each shift. The health and safety representative was unavailable on the day of the audit.</p> <p>Resident meetings are held three monthly, agenda items include updates within the facility, and residents have the opportunity to provide feedback on the services provided.</p> <p>There have been no resident or relative satisfaction surveys completed since 2017.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Falls data is discussed at all meetings, and the staff have had training on falls prevention.</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>St Barnabas documents and analyses incidents/accidents, unplanned or untoward events, and provides feedback to the service and staff so that improvements are made. Individual incident reports are completed for each incident/accident with immediate action noted and any follow-up action required. Minutes of the quality meetings, and health and safety meetings reflect a discussion of incidents/accidents and actions taken.</p> <p>Thirteen incident/accident forms were reviewed. All demonstrated that there was clinical follow-up by an RN, the falls risk assessment tool is updated and attached to the incident report. Opportunities to minimise future risks have been identified. The previous finding has been addressed.</p> <p>Incident forms have a section to indicate if family have been informed (or not) of an incident/accident, and these were fully completed, and the reason was documented if the notification did not occur.</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</p> | FA | <p>Six staff files were reviewed (the care manager, three caregivers, one diversional therapist and one kitchen supervisor), all included up-to-date documentation, training records are maintained on the online system. Relevant checks were completed to validate the individual's qualifications, experience and veracity. A copy of practicing certificates is maintained in the staff files.</p> <p>The service has an online staff training package, caregivers and the managers interviewed, reported most staff members have commenced this training. The care manager is providing one-on-one sessions for those less confident with the system. There is a two-yearly education programme that covers contractual requirements. Attendance records have been maintained and overall attendances average 56% completion of the online sessions. Compulsory sessions such as infection control, chemical safety and medications have 100%</p> |

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| <p>requirements of legislation.</p> | | <p>completion, restraint, elder abuse and a second falls management had 88% completion. Manual handling and falls prevention have 72% completion. The previous finding has been addressed.</p> <p>The line managers have attended a leadership and management workshop. Staff who administer medication have current medication competencies that include warfarin and insulin management competency. Four caregivers interviewed confirmed that they have completed competencies at least yearly or earlier if required by the care manager following a medication error. Two RNs are interRAI trained. Careerforce qualifications are available for caregivers. St Barnabas currently have seven caregivers with level 2, three with level 3 and two caregivers with level 4. Two staff are currently completing level 3 training and one caregiver is completing level 2.</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>The service maintains stable staffing and the acting manager described staff turnover as low. The manager (RN) works full-time. There are also two registered nurses (the care manager and quality manager) who both work five days per week and provide on-call. At the time of the audit there were 39 residents.</p> <p>They are supported by four caregivers on the morning shift 2 x 6.45 am to 3.15 pm and 2 x 8 am to 1 pm. All three caregivers are medicine competent.</p> <p>On the afternoon shift there are three caregivers; 2 x 2.45 pm to 11.15 pm who are medicine competent, and 1 x 4.30 pm to 7.30 pm who can be a second checker for medications.</p> <p>Night shift has two caregivers from 10.45 pm to 7.15 am who are medicine competent.</p> <p>All permanent staff have current first aid certificates. There is a rotating roster of 4 on 2 off except the 8 am to 1 pm who chose the 6 on 2 off roster.</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>FA</p> | <p>The facility has implemented an electronic medication management system. The respite resident has paper-based medication charts, which were clearly written, signing sheets were correctly documented, and PRN medications indicate use, time administered and effectiveness.</p> <p>Eighteen medication charts and signing sheets were reviewed and reflected medications were administered as prescribed. Medications have been reviewed three-monthly with medical reviews by the attending GP. All 'as required' (PRN) medications included reason for administration and efficacy documented. Resident photos and documented allergies or 'nil known' were documented on all medication charts reviewed. An annual medication administration competency was completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedures in place. There were currently two residents who self-administered medications who have documented medication competencies on file, medications are stored in a locked drawer in the resident's room. All eye drops had been dated on opening and weekly medication checks</p> |

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| | | have been documented. The previous finding has been addressed. |
| <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> | FA | <p>All meals at St Barnabas are prepared and cooked on-site. The service has a large kitchen, which also provides meals for outside agencies such as meals on wheels. There is a food verification certificate 'A' grade and a food control plan expiring 30 May 2020. There is a menu, which had been reviewed by a dietitian in 2018.</p> <p>All monitoring such as fridge, freezer and food temperatures have been documented. Diets are modified as required. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen. Supplements are provided to residents with identified weight loss issues.</p> <p>Kitchen staff serve the meals from a bain marie in the dining room (opposite the kitchen) which allows the opportunity for resident feedback on the meals and food services generally. Residents and the relative interviewed were very complimentary of the food service. The kitchen manager is part of the combined quality, health and safety meetings and is part of the management team. Fridge and freezer temperatures are monitored and recorded daily and are within range.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>All risk assessments have been completed at least six monthly along with the interRAI assessment. All interRAI assessments in the resident files reviewed have been completed on time. Outcomes of the interRAI and risk assessments are reflected in the care plans. The RNs describe when they have completed reassessments for changes in condition and for higher levels of care. There is a new "Authorisation for 3-month GP visits" form that has been introduced since the last audit for the GP to sign when residents' condition is stable. Risk assessments such as the falls assessment is completed after each fall. Pain is recorded in the electronic medication system which can be remotely accessed by the GP. The previous finding has been addressed.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | PA Moderate | <p>Overall the care plans reviewed reflected the outcomes of the risk assessments and interRAI assessment in the momentum system. There was documented evidence of resident and relative involvement in the care planning process. All files sampled included a care plan and demonstrated service integration and input from allied health, and include side effects of medication, however, interventions in either long or short-term care plans do not always reflect changes in health status. This was addressed on the day of the audit. The previous finding has been partially addressed.</p> |
| <p>Standard 1.3.6:</p> | FA | <p>When a resident's condition alters, the RN initiates a review and if required a GP visit. Communication to the GP</p> |

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| <p>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | | <p>for a residents' change in health status were sighted in the residents' files. A falls assessment has been completed post falls. The previous finding has been addressed. Residents interviewed reported their needs were being met. Caregivers interviewed were very knowledgeable regarding resident care needs. Relatives and the GP commented positively of the care provided to residents.</p> <p>Staff have access to sufficient medical supplies including dressings. Wound documentation is available and includes assessments, management plans, progress and evaluations. There was one resident with a skin tear on the day of the audit, this wound had an assessment, plan and evaluation documenting progression or deterioration of the wound. The RNs reported chronic wounds are reviewed by the GP. The RNs have access to the wound care specialist if required.</p> <p>There are sufficient continence products available and resident files sampled included a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Monitoring forms are in place for vital signs including weight, wounds, pain, behaviour management, and food and pain management.</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>St Barnabas employs a diversional therapist who works 65 hours a fortnight across Monday – Friday. Activities are provided for each morning and afternoon from Monday to Friday.</p> <p>The programme is developed monthly. Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed by the diversional therapist (DT) for the resident files sampled. The activities programme reflects the residents' cognitive and physical abilities including a percussion group, a knit and yarn group, crafts and various group activities, there are weekly planned visits to the community. St Barnabas has recently purchased a new van for resident outings, the residents trialed various vans and had a say in the van purchased for the facility. There are weekly happy hours and local entertainers visit and entertain residents. One-on-one activities are available for residents who prefer not to engage in group activities. Celebrations and anniversaries are celebrated, with plans underway for pink ribbon day. The kitchen staff are involved in planning for celebrations and come up with themed foods for the day.</p> <p>Throughout the audit, residents were viewed enjoying activities with the DT. There are resident meetings, where residents are part of planning activities for the next month. Church services are provided on a regular basis. Mass is held monthly. Residents and relatives interviewed commented that activities meet resident needs and there is always plenty going on.</p> |
| <p>Standard 1.3.8: Evaluation</p> | <p>FA</p> | <p>Care plans reviewed had been evaluated by RNs six-monthly. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. Changes to resident health status is not</p> |

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| <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | | <p>always updated in the care plans (link 1.3.5.2).</p> <p>Relatives are notified of the outcome of the GP review if unable to attend. There is at least a three-monthly review by the medical practitioner. The relative interviewed confirmed they are invited to attend the GP reviews, and feel they are well informed of any changes.</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 warrant of fitness checks have occurred, however the service did not meet the original requirements. The board and the council have addressed this. Contractors were attended to the non-compliances. A Building WOF has since been approved and expires 3 March 2020. There are preventative and reactive maintenance schedules maintained and corrective actions are signed and dated on completion. All equipment has been tagged and tested. All hoists, medical equipment and weigh scales have been calibrated, tagged and tested. There is a preventative maintenance schedule in place. Hot water temperatures are checked monthly and are within safe parameters. If there are concerns, corrective actions are implemented. Outdoor areas are easily accessible for residents, there is a current proposal in place to build a pergola for the garden. All communal areas have wheelchair access. Resident rooms are spacious and personalised to individual taste.</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> | <p>FA</p> | <p>Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the senior management meetings, quality meetings, and three-monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. There have been no outbreaks since the previous audit.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>St Barnabas is restraint-free and there were no residents using enablers. Restraint/enabler use, and restraint minimisation are discussed at senior management meetings, at staff meetings and at the three-monthly quality meetings. Staff have received training around restraint minimisation.</p> |

Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding | Corrective action required and timeframe for completion (days) |
|---|-------------------|---|---|--|
| <p>Criterion 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p> | PA Low | The last satisfaction survey was completed in 2017, the results were analysed, and corrective actions developed and signed off. There were a range of clinical, infection control and household and health and safety internal audits completed until July 2018, all corrective actions identified were signed off as completed, and these were discussed at all meetings. All cleaning, laundry and safety internal audits have been completed monthly to date; however, no clinical internal audits have occurred in the last ten months. | <p>i) There have been no satisfaction surveys completed since 2017.</p> <p>ii) There have been no clinical audits including infection control, medications, resident files and food services completed since July 2018.</p> | <p>Ensure all surveys and internal audits occur as planned.</p> <p>90 days</p> |
| Criterion 1.3.5.2 | PA | Long term care plans reflect allied health input. Short-term care plans are available for use to document any changes in health needs with | i) One resident file did not have interventions | Ensure short-term care |

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| <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | <p>Moderate</p> | <p>interventions, management and evaluations, however, are not always utilised. Medical GP notes and allied health professional progress notes are evident in the resident's integrated file and on the electronic medicine charting system.</p> | <p>in place for caregivers to follow for a current wound and dressing.</p> <p>ii) One resident with changes in swallowing and a current infection had no interventions on recent weight loss, food and fluid monitoring, and management of the infection.</p> | <p>plans are documented or long-term care plans updated for short-term/acute needs.</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.

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End of the report.