

Aspen Lifecare Limited- Aspen

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:	Aspen Lifecare Limited
Premises audited:	Aspen
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 June 2019 End date: 27 June 2019
Proposed changes to current services (if any):	One resident room has been decommissioned and now being used as an office. This reduces overall bed numbers from 57 to 56 beds.
Total beds occupied across all premises included in the audit on the first day of the audit:	53



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

Aspen Lifecare provides rest home and hospital level care for up to 56 residents. At the time of the audit there were 53 residents in total. The residents, relatives and general practitioner commented positively on the care and services provided at Aspen Lifecare.

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 service is managed by a facility manager who has been at Aspen Lifecare since January 2018 and has worked in the aged care sector in clinical and facility management roles for over 20 years. She is supported by a clinical services manager and an administrator.

Five of the eight shortfalls identified as part of the audit have been addressed. These were around admission agreements, mandatory training, infection control training, activities and timeframes for documentation. Improvements continue to be required around quality processes, human resource management, care plan documentation, and care plan implementation.

This audit has identified improvements required around orientations, self-medication management and medication competencies.

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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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. Complaint processes are implemented, and complaints and concerns are actively managed and well documented.

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.
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Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. Meeting minutes include discussion of quality data. Corrective actions are put into place where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Recruitment processes are managed in accordance with good employment practice. An education and training plan is being implemented.

Registered nursing cover is provided 24 hours a day, 7 days a week.

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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The registered nurse is responsible for each stage of service provision. The assessments, initial and long-term nursing care plans are developed in consultation with the resident/family/whānau. Long-term care plans are reviewed at least six-monthly or earlier if there is a change in health status. The activity programme is developed to promote resident independence and social interaction. Residents interviewed spoke positively about the activity programme. Medication policies reflect guidelines. Food services and meals are prepared on site. There has been a dietitian review of the menu. All kitchen staff have been trained in food safety and hygiene.

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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The building has a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. During the audit, there were no residents using a restraint and two hospital level residents using an enabler (one lap belt and one bedrail).

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 nurse has attended external education and coordinates education and training for staff. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Infection prevention and control is integrated into full staff and registered nurse meetings. There is a suite of infection control policies and guidelines to support practice.

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	15	0	1	4	0	0
Criteria	0	40	0	2	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents were all signed correctly. There is evidence of discussion with family when the general practitioner (GP) has completed a clinically indicated not for resuscitation order. Healthcare assistants and RNs interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. All resident files sampled had a signed admission agreement on file, this is an improvement from the previous audit.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is</p>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints.</p> <p>A complaints register is maintained. Complaints are being managed in a timely manner, meeting the requirements determined by the Health and Disability Commissioner (HDC). Four complaints have been lodged in 2019 (year to</p>

<p>understood, respected, and upheld.</p>		<p>date). Evidence of acknowledgement, an investigation and outcomes were documented for all four complaints. Corrective actions have been implemented as a result of a lodged complaint (where indicated). The complaints process is linked to the quality and risk management system. Evidence of complaints being discussed in meetings were sighted in meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Six residents interviewed (four hospital level and two rest home level including one resident on respite and one resident on the long-term support – chronic health conditions (LTS-CHC contract)) stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incidents/accident reports were reviewed which indicated that family were informed about the event. Three (hospital level) relatives interviewed confirmed that they are notified regarding changes in their family member's health status. Interpreter services are available 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>Aspen Lifecare provides rest home and hospital level care (medical and geriatric services) for up to 56 residents. This is a reduction of one room that has been permanently converted to office space. There are 11 designated rest home beds and 45 beds suitable for dual-purpose use. At the time of the audit there were 53 residents (27 rest home and 26 hospital). Two residents (one rest home and one hospital) were on a long-term support – chronic healthcare condition (LTS-CHC) contract; and two residents (rest home) were on respite care.</p> <p>Aspen Lifecare has a business and quality plan (2019-2020) in place that is regularly reviewed by the manager and is linked to management and board meetings.</p> <p>The service is managed by a facility manager who is an RN and has worked in the aged care sector for 25 years. She has been at Aspen Lifecare since January 2018. She is supported by a clinical manager who previously was a staff RN at the facility and has been in the role for one year.</p> <p>The facility manager and clinical manager have completed a minimum of eight hours of professional development activities related to their roles.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation</p>	<p>FA</p>	<p>During a temporary absence of the facility manager, the clinical services manager covers the role with support from the administrator and care staff.</p>

<p>ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</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>	<p>PA Moderate</p>	<p>The quality and risk management system has been purchased by the Cavell Group, but has not yet been implemented. Previous standard operating procedures (Heritage Lifecare Limited) were being used at the time of this spot audit. Interviews with seven staff (three healthcare assistants (HCAs), one RN, one maintenance, one activities coordinator, one cook) confirmed their understanding of the quality and risk systems being used. Resident meetings are held three-monthly and minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff.</p> <p>The service has policies and procedures through Heritage Lifecare Limited that were current but were from the previous owner. Work is underway to implement the Cavell policies and procedures.</p> <p>The service documents and analyses incidents/accidents, infections, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. This is the responsibility of the clinical manager. Monthly results are posted in the staff room and are discussed in meetings. Missing was evidence of the implementation of an internal audit programme. This previous area identified for improvement remains.</p> <p>Corrective actions were evidenced where opportunities for improvements were identified (examples provided since the previous audit include (but are not limited to) temperature checks in the kitchen, food safety training, implementing an early alert system for unwell residents, upgrades to the call bell system).</p> <p>Health and safety policies are implemented and monitored and are linked to quality meetings. Risk management, hazard control and emergency policies and procedures are implemented. There are procedures to guide staff in managing clinical and non-clinical emergencies.</p> <p>Falls prevention strategies are in place including routine visual checks, sensor mats and interventions specific to each individual resident.</p>
<p>Standard 1.2.4: Adverse Event</p>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident</p>

<p>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>reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of fifteen incident/accident reports identified that each report is fully completed and includes follow-up by a RN. Neurological observations are carried out for any suspected injury to the head. Incidents/accidents are linked to the quality and risk management programme.</p> <p>The facility manager interviewed identified situations that would be reported to statutory authorities with an example provided (wandering resident).</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>PA Moderate</p>	<p>Human resources policies cover recruitment, selection, orientation and staff training and development. Five staff files reviewed of staff employed since the last audit (one clinical manager, four healthcare assistants) reflected evidence of a recruitment process which included reference checking, signed employment contracts, signed job descriptions and police checks. Missing was evidence of staff completing an orientation programme. This gap was confirmed by the facility manager. A register of RN staff and other health practitioner practising certificates is maintained.</p> <p>There is an implemented annual education and training plan with an attendance register for each training session. Attendance at mandatory training is monitored. Mandatory training was up to date and the previous shortfall has been addressed. Annual medication competencies for RN staff were behind schedule (link 1.3.12.3). Six of seven RNs (including the clinical manager) have completed their interRAI 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</p>	<p>FA</p>	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager/RN and clinical manager/RN who work Monday to Friday.</p> <p>The staff roster covers the facility as a whole (27 rest home and 26 hospital) and is not broken down into wings. One RN and one EN (or two RNs) cover the AM and PM shifts and one RN covers the night shift. Seven HCAs are rostered on the AM shift (three long and four short), and seven HCAs are rostered on the PM shift (two long and five short). Two long shift HCAs are rostered on the night shift.</p> <p>Agency healthcare assistants are used to cover absences if needed, but staff RNs report that they prefer to work extra shifts rather than use agency staff. There are separate cleaning and laundry staff.</p> <p>Staff working on the days of the audit were visible and attending to call bells in a timely manner. The call bell</p>

<p>providers.</p>		<p>system has recently been upgraded which has improved the timeliness of responding to call bells. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Staffing can be increased if resident acuity is high. Residents and family members interviewed reported there are sufficient staff numbers.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet current guidelines. The RNs, ENs and senior HCAs who administer medications have not all completed annual medication competencies. Annual in-service education on medication is provided by the supplying pharmacist. Medications (robotic rolls) are checked on delivery against the medication chart and any discrepancies fed back to the pharmacy. Medications administered by staff were stored safely in the two nurses' stations. Standing orders are in use and meet the medication administration guidelines. There were two self-medicating residents who had a self-medication competency completed and reviewed three monthly by the GP, but medications were not stored securely.</p> <p>The medication fridge is monitored daily. All eye drops were dated on opening. Nine electronic and one paper-based medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three monthly. The electronic administration signing sheets reviewed identified medications had been administered as prescribed. Prescribed 'as required' medications include the indication for use. The doses and time given is signed for on the administration signing sheet. Pain monitoring forms record the effectiveness of pain relief.</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>There is a fully equipped kitchen in the facility. Most of the food is prepared and cooked on-site. There are two cooks who cover seven days a week, who are supported by kitchen assistants. All kitchen staff have completed food safety training. The menu has been approved by a dietitian. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines.</p> <p>All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. Food in the freezer and fridge was labelled and dated. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for and alternative meals can be accommodated if needed. Residents' weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</p> <p>Meals observed were well managed and adequately staffed and staff were observed assisting resident's with hand wipes prior to meals.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The long-term care plans reviewed included reference to all identified needs; but did not include the interventions needed to address all the identified risks. The plans identified allied health involvement under a range of template headings. The interRAI assessment and other assessment tools undertaken were used to inform the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Staff interviewed reported they found the long-term care plans easy to follow. Short-term care plans did not document the nursing interventions needed. Care plan documentation is a continued shortfall from the previous audit.</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.</p> <p>Not all care interventions described for residents were documented as occurring. 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. Staff described a handover between each shift and stated that they are very well informed regarding resident needs. Care staff interviewed were able to discuss individual care.</p> <p>There were 14 wounds logged at the time of the audit. One resident had a grade two pressure injury and two had a grade one. Assessments, management plans and documented reviews were in place for all wounds. Wound care documentation is an improvement from the previous audit.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available during the week to assist with mobility assessments and the exercise programme.</p> <p>Monitoring records sighted (weights, food and fluids, neurological observations and turning charts) were consistently completed, but not wandering charts.</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 appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>An activity coordinator is employed from seven hours a day Monday to Friday to coordinate and implement an activity programme that meets the recreational needs of the resident groups. The activity coordinator has experience as an HCA at Aspen Lifecare and has been in the role for four months. She attends on site in-service and is enrolled in the Careerforce diversional therapy programme. Activities continue to take place in the lounges and follow a documented programme. Residents from all areas are encouraged to attend the daily programme. Entertainment occurs in the weekends. There are visiting churches, library, grammar school students and pet therapy. All festivities and birthdays are celebrated. Outings into the community include shopping, picnics and outings to the local RSA for lunch. Residents are supported to attend their own church and other community functions. A resident activity assessment is completed on admission. Each long-term resident has an individual activity plan which is reviewed six monthly.</p>

service.		The service receives feedback on activities through one-on-one feedback, residents' meetings and surveys. Residents and family interviewed confirmed participation is voluntary. Residents from all areas were partaking in activities during the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	The RNs evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plans were evaluated at least six monthly or earlier. Evaluations were documented and stated either that goals were achieved or not achieved, and progress documented through the interRAI process. The RN completing the care plan signs the care plan reviews.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 26 February 2020. There is a part-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment is serviced and/or calibrated annually. Essential contractors are available 24 hours. Hot water temperatures are monitored two-monthly. Residents were observed to safely mobilise throughout the facility.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control coordinator is responsible for coordinating/providing education and training to staff. The infection control coordinator has completed specific infection control education since being in the role and this is an improvement on previous audit.
Standard 3.5: Surveillance Surveillance for infection is carried out	FA	The infection control programme describes and outlines the purpose and methodology for the surveillance of infections. 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. Short-term care plans are used. This data is monitored and evaluated monthly and annually. The infection control programme is linked with the quality

<p>in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>management programme (link 1.2.3.6). Outcomes and actions are discussed at the RN/EN meetings. There has been one outbreak since the previous audit.</p> <p>There is close liaison with the nurse practitioners that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</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>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. During the audit, there were no residents using a restraint and two hospital level residents using an enabler (one lap belt and one bedrail).</p> <p>One file of a resident using an enabler (bedrail) was selected for review. The enabler assessment is linked to the enabler consent form. Risks associated with this type of enabler are identified as well as the rationale for enabler use. The enabler is reviewed six-monthly by the multidisciplinary team, including the GP, with voluntary written consent provided by the resident (sighted).</p> <p>Annual staff training is in place around restraint minimisation and enablers. Training is linked to a written competency assessment. Completion of training and the written competency is mandatory and is linked to each employee's annual performance appraisal.</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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Moderate	Adverse event data is monitored monthly with trends identified and analysed. Other internal audit processes currently in place include monitoring resident satisfaction via surveys, a kitchen audit, monitoring of hazards and monitoring the internal environment. These results are communicated to staff via information posted in the staff room and in meeting minutes. Missing was evidence of an internal audit schedule with evidence of its implementation. Since the draft report the manager advised that an internal audit schedule for all aspects of service has been revised. They have developed a new audit schedule, with regular internal audits commenced.	Only certain aspects of an internal audit programme have been implemented. There is no internal audit schedule and no service delivery internal audits are completed.	Ensure an internal audit programme is implemented that monitors all aspects of the service. 90 days
Criterion 1.2.7.4 New service	PA Moderate	An orientation programme is established to provide new staff with relevant information for safe work practice. Interviews with staff confirmed that they	One of five staff files reviewed evidenced	Ensure that there is

providers receive an orientation/induction programme that covers the essential components of the service provided.		were orientated to their new roles. The documentation to evidence this was missing in the five staff HR files reviewed.	an orientation programme that was partially completed, and four staff files failed to indicate that staff had completed their orientation programme.	documented evidence to confirm staff have completed an orientation programme. 90 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	The RNs, ENs and senior HCAs who administer medications have not all completed annual medication competencies. Annual in-service education on medication is provided by the supplying pharmacist.	Staff who administer medications did not all have up-to-date medication competencies. Seven RN medication competencies were last completed in Feb 2018.	Ensure staff competencies are up to date 90 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	The service facilitates self-administration of medications for residents. Two resident who self-administer had assessments and consents in place approved by the GP. The RNs check each day to ensure compliance. The two residents both had their medications stored in a cupboard, but the cupboards had no lock.	Two residents who self-administer medications did not store medications in a lockable area in their rooms due to the large size of the bottle.	Ensure the residents who self-administer secure their medications in a lockable area. 90 days
Criterion 1.3.5.2 Service delivery	PA Moderate	The RN is responsible for completing all necessary assessments prior to documenting the care plan. This is an improvement from the previous audit. Long-term care plans were not reflective of all assessed needs and the	i) The respite resident's care plan was not fully	Ensure each residents care plan

<p>plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>respite resident's care plan was not fully completed. Two short-term care plans for infections did not document the nursing care interventions, only the need for antibiotics. Care plan interventions is a continuing shortfall from the previous audit.</p>	<p>completed. ii) One rest home resident with seizures did not have recognition and interventions documented. iii) Two short-term care plans for an infection did not document interventions, only the administration of antibiotics.</p>	<p>includes interventions to meet all assessed needs. 60 days</p>
<p>Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>The RNs are responsible for wound dressings including wound management plans and referrals to the GP or wound nurse specialist as required. Assessments, management plans and documented reviews were in place for all wounds. Care plans documented monitoring information, but this was not always documented as occurring.</p>	<p>One hospital level resident with a history of wandering did not have all checks documented. A location tracker was documented as in place in the care plan but was not in use (due to repairs).</p>	<p>Ensure that all monitoring is documented as occurring as per care plan 90 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.