# Komal Holdings Limited - Homestead Ilam Home and Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Komal Holdings Limited

**Premises audited:** Homestead Ilam Home and Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 8 July 2019 End date: 9 July 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:** 35

# 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 |
|  | 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

Homestead Ilam provides care for up to 39 rest home and hospital (geriatric and medical) level residents. On the days of audit there were 35 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 facility is managed by the (non-clinical) owner who also owns another facility. The owner is supported by a nurse manager who is an experienced aged care registered nurse. A quality coordinator, also a registered nurse, is employed to support the management team.

Residents, relatives and the GP interviewed spoke positively about the service provided.

Two of five previous findings around staff orientation documentation and the environment have been addressed. Improvement continues to be required around training, staff rostering and care planning. This audit identified additional improvements required around interRAI and care planning timeframes, monitoring charts and aspects of medication management.

## 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. |

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

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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 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. The quality system has been implemented. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. 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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| --- | --- | --- |
| 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. |

Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Comprehensive service information is available. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations.

Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate and are evaluated. There is medication management policies and procedures. 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 diversional 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 and relatives reported satisfaction with the food service. A food control plan is implemented.

## Safe and appropriate environment

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

The building has a current warrant of fitness and emergency evacuation plan. There is an approved fire evacuation plan. Fire evacuations have been undertaken six monthly. There is sufficient space to allow the movement of residents around the facility using mobility aids. Electrical testing has been completed as required. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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 policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with a restraint and three residents using enablers.

## Infection prevention and control

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| --- | --- | --- |
| 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 | 11 | 0 | 3 | 3 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 3 | 3 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. A paper-based record of all complaints is maintained by the facility manager using a complaints’ register. There have been four complaints for 2018 and two complaints for 2019 year-to-date. Complaints include written and verbal complaints, and complaints have been generated from adverse event investigations. All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents interviewed and family members advised that they are aware of the complaint’s procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Evidence:  Residents (three rest home and two hospital residents) and four relatives (one hospital and three rest home) were interviewed. Residents’ stated they were welcomed on entry and were 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. The accident/incident form includes a section to record family notification. All ten forms reviewed evidenced family had been notified.  Interpreter services are available as required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Homestead Ilam provides care for up to 39 rest home and hospital level residents. Thirty-seven of thirty-nine beds are dual-purpose (two beds are rest home only). On the days of audit there were 35 residents. Ten residents were receiving rest home level care (including two on an LTS-CHC and one respite resident) and twenty-five were receiving hospital (including one on an end of life contract) level care. All other residents were on the age-related care contract (ARCC).  The facility is managed by a part time (non-clinical) owner. The owner also owns another facility. She has attended at least eight hours of training related to elderly care management in the last year. The owner is supported by a clinical manager who has been employed in the role for nine months but has worked at the service for ten years. The clinical manager works 40 hours per week and provides on-call after hours and weekends. A quality coordinator, also a registered nurse is employed for two days a week on quality and two days a week on the floor. The clinical manager has completed at least eight hours of professional development around the management of a hospital facility.  There is a documented 2019 to 2020 business plan. Organisational and quality objectives are defined with evidence of monthly reviews. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There are quality goals and a risk management plan for Homestead Ilam. There is evidence that the quality system continues to be implemented at the service. Interviews with staff confirmed that quality data such as incident/accident, infection control, restraint, internal audits, concerns and complaints are discussed at bi-monthly staff and quality meetings and monthly caregiver meetings. The service's policies are reviewed by an external contractor every two years, or sooner if required. Staff have access to policy manuals.  Data is collected in relation to a variety of quality activities and a comprehensive internal audit plan is implemented. Areas of non-compliance identified through quality activities are actioned for improvement. Comprehensive monthly reports on accident/incident and infection reports are provided.  Annual resident/relative satisfaction survey results are collated and summarised. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. The most recent family/resident survey completed in March 2019 achieved 93% for communication. A food survey from July 2018 identified overall satisfaction with most meals. The service has acted on areas where opportunities to improve were identified.  The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. One of three health and safety representatives (interviewed) has a good understanding of the requirements of the role. She has completed health and safety training.  Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the clinical manager and analysis of incident trends occurs. There is a discussion of incidents/accidents at bi-monthly quality meetings and monthly staff and clinical meetings, including actions to minimise recurrence. Clinical follow-up of residents is conducted by a registered nurse as evidenced in the ten incident forms sampled. Neurological observations were completed for unwitnessed falls where clinically indicated. Care plan interventions and/or short-term care plans were in place where needed following a resident fall. Discussions with the clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Relevant authorities were notified of a norovirus outbreak in 2018 and section 31 notifications were made in relation to wandering residents and a fall resulting in a fracture. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Six staff files were reviewed (cook, two caregivers, two RNs and diversional therapist). All files included appropriate employment documentation. Completed orientation documentation was on staff files and this is an improvement on previous audit. A register of practising certificates is maintained. Staff turnover was reported as stable.  The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.  A completed in-service calendar for 2018 exceeded eight hours annually. An annual programme for 2019 is being implemented. There is a structured education programme for all staff. All compulsory subjects have been provided in the last two years and attendance reflects above 50% of care staff at compulsory sessions. This aspect of the previous partial attainment has been addressed. However current performance appraisals were not all up to date. A corrective action plan is in place to ensure all performance reviews are completed by the end of July. Registered nurses (RNs) are provided opportunities for training from the DHB and attend external first aid and NikiT training. The clinical nurse manager and registered nurses are able to attend external training such as seminars and education sessions with the local DHB. Six of the current eight RNs are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | Organisational staffing policy aligns with contractual requirements and includes skill mixes. Staff reported the owner/manager works between one and three days a week and was away on annual leave on the day of audit. Staff reported the manager has been away on leave on several occasions recently. The clinical nurse manager works 40 hours a week and provides 24 hour on-call and RN cover as required. The quality coordinator (RN) works two days per week in the quality role and two days per week as an RN.  Staffing for the rest home and hospital includes:  There is one RN on duty each shift. There are six caregivers rostered in morning shift (two eight-hour shifts, one six and three quarter and three six-hour shifts). There are five caregivers rostered on afternoon shifts (one full shift, one six-and-a-half-hour shift, one five hour, one four hour and one three-hour shift). There is one caregiver on the night shift. Residents and families interviewed confirmed that staffing numbers were usually appropriate. Staff interviewed stated that they do not always have sufficient staffing levels. This continues to be an area requiring improvement. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | There are policies available for safe medicine management that meet legislative requirements. All medications are stored appropriately in a clean, secure, clinical room and medication area, however not all eye and nasal sprays in use were dated on opening. Twelve medication charts were reviewed. All medication charts sampled were legible, up-to-date and reviewed at least three-monthly by the GP. All ‘as required’ medication charts included an indication for use. Controlled drug medication was checked weekly, however not all entries in the controlled drug register evidenced the time of administration.  The RN and caregivers who administer medications had been assessed for competency and attended education on an annual basis. A caregiver was observed to be safely administering medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Review of paper-based administration identified medication was not always signed each time a medicine was given by staff. There are no standing orders in use.  There is currently one rest home resident who self-administers inhalers, this is managed appropriately.  The medication fridge temperature is recorded regularly and is within the acceptable ranges. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Homestead Ilam employs an experienced cook and all food is cooked on site. A verified food control plan is in place. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and this is provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the cook works closely with the registered nurses on duty. The kitchen staff have completed food safety and chemical safety training. The cooks follow a rotating seasonal menu, which was reviewed in April 2016 by a dietitian. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately.  Individual resident likes and dislikes are accommodated. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. Resident meetings and surveys allow the opportunity for resident feedback on the meals and food services generally. Residents and the family members interviewed were very happy with the quality and variety of food served.  The kitchen and dining room have been recently renovated. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | Care plans are individually developed with the resident, and family involvement is included where appropriate. The RN is responsible for all aspects of care planning. It was not always clear what interventions were current and what was obsolete, and this continues to be an area requiring improvement. InterRAIs have not always informed the care plans in a timely manner due to the interRAI not always being completed before the care plan (link 1.3.3.3). Assessments and care plans included input from allied health professionals. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | The registered nurse and caregivers follow the care plan and report progress against the plan at least daily or more frequently if needed. If external medical advice is required, this will be actioned by the GP. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Registered nurses could describe access to continence specialist input as required.  There were three documented wounds at the time of audit. Wound care is undertaken by the registered nurses. Wound care assessments, plans and reviews including photographs were documented for all wounds and there was evidence of GP involvement in the management of wounds. Wounds included; two surgical wounds and a skin tear.  Interviews with the registered nurse and caregivers demonstrated an understanding of the residents in their care. Monitoring forms are in use. Forms sighted included monthly blood pressure and weights, pain monitoring, nutritional and food monitoring and behaviour monitoring and turning charts. Monitoring charts are not always completed as required. |
| Standard 1.3.7: Planned Activities  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. | FA | The diversional therapist works 35 hours per week with flexibility to work weekends if required. An enthusiastic and experienced diversional therapist provides a wide range of activities, addressing the abilities and needs of different residents (rest home and hospital). The attendance rate is high with residents of different abilities being supported to enthusiastically join in the activities. An enlarged copy of the programme is delivered to each resident’s room.  Activities provided are often in response to resident suggestions and has included a picnic lunch to Akaroa, movies at a local cinema, and a visit to Orana Park. Residents have fundraised for activities ensuring all can attend. Residents and families interviewed provided positive feedback in relation to oil painting classes, sewing groups and individual music therapy. There is also significant engagement with the community including outings to clubs and concerts and a variety of groups and individuals from children to older people visit the service. The service has a relationship with a local high school which includes work experience. Special events including (but not limited to); Christmas, Easter, Mother’s Day and Anzac Day are celebrated. A well-attended bible group is provided weekly by a resident who was previously a church minister. Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents’ wellbeing.  On admission, the diversional therapist completes an assessment for each resident and an activity plan is completed. A record is kept of individual resident’s activities and progress notes are completed monthly. Reviews are conducted six-monthly (or earlier should the residents condition determine) as part of the care plan evaluation/review.  The diversional therapist is proactive in providing meaningful and enjoyable experiences for all residents at Homestead Ilam. Residents’ interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans, however not all were completed within three weeks of admission (link 1.3.3.3). Files sampled demonstrated that the long-term nursing care plan was evaluated at least six-monthly or earlier if there is a change in health status, however, evaluations did not always align with interRAI reassessments (link 1.3.3.3). There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. |
| 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 which expires on 1 June 2020. An external provider checks fire equipment. There is a maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. There are outside areas with seating, tables and shaded areas that are easily accessible. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. The kitchen and dining area have recently been extensively renovated, with structural repairs completed, new equipment and flooring. All flooring surfaces have been made safe and are no longer a trip hazard. The previous partial attainment has been addressed. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections were entered onto a monthly facility infection summary and staff were informed. This data is monitored and evaluated three monthly and annually. A gastroenteritis outbreak in July 2018 was appropriately managed, with notification to the relevant authority. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with a restraint and four residents using enablers (two lap belts, one bed rails and one using bedrails a lap belt and a tray table). The file for two of the residents using enablers reflects a restraint/enabler assessment and voluntary consent by the resident. |

# 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 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is a structured education programme for all staff. All compulsory subjects have been provided in the last two years and attendance reflects above 50% of care staff at compulsory sessions. This aspect of the previous partial attainment has been addressed. Annual performance appraisals are scheduled and provide an opportunity to identify areas for improvement or areas of interest and develop plans to meet these. While annual appraisals have been scheduled, the clinical nurse manager has frequently covered for staffing shortages and as a result has been unable to complete these as planned. The service is aware of this this and has a corrective action plan in place. | Three of six staff files reviewed did not have an appraisal completed in the last 18 months | Ensure all staff have annual performance appraisals as per policy.  90 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | The service has a staffing roster in place, residents stated they are well cared for. Registered staff reported that they have recently worked additional hours to provide 24-hour RN cover. A new RN has been employed and is currently completing orientation. All staff interviewed felt that the caregiver staffing was often low and commented that leave was not always covered. | Discussion with both senior care staff and caregivers evidenced that staff continue to be concerned regarding staffing levels; particularly at the weekends. The clinical nurse manager has covered on the floor on several occasions recently (including two-night shifts in the last two weeks) and is working long hours to manage her own role. A review of the staffing roster and staff on duty over two consecutive weeks evidenced that; the diversional therapist was not replaced for five days; eleven of fourteen morning shifts and four of fourteen afternoon shifts were not fully staffed as per planned roster. It was also noted that for the last two weeks several staff have worked additional shifts. Staff reported that agency staff are utilised on rare occasions to cover RN shifts but are not used for caregiver shifts. Staff also stated that all staff including the CNM, quality nurse, DT and RNs worked together to provide resident care. | Review the staffing and ensure there are enough staff to fully staff the roster.  30 days |
| Criterion 1.3.12.1  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. | PA Moderate | Medication is safely stored in a secure clinical area. All medication is checked by registered nurses and expired medications returned to pharmacy. Not all eye drops and nasal sprays in current use were dated on opening.  Medication charts reviewed identified that controlled drugs were appropriately prescribed. Signing charts for controlled drugs and the controlled medication register documented two staff always sign for medication. The time of administration is not always recorded in the controlled drug register.  All medication is signed for on paper administration charts. Where medication is not given, the nurses or medication competent care staff document the reason, however this was not always documented as required. | (i)Two eyedrops and one nasal spray in current use were not dated on opening.  (ii) Five recent entries in the controlled medication chart did not evidence the time of administration.  (iii)There are a number of gaps evident in the signing chart | (i). Ensure all eyedrop and nasal sprays are dated on opening and discarded as per manufacturer’s instructions.  (ii). Ensure all entries in the controlled drug register include the time of administration.  (iii). Ensure all medication is signed when  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | RNs are responsible for completing interRAI assessments and care plans within 21 days of admission and reviewing six monthly. Two of three files where an interRAI assessment was required had this completed within 21 days of admission. Two of five residents’ files evidenced initial long-term care plans were completed within 21 days of admission. | Not all interRAI assessments and care plans were completed in required timeframes.  (i) Initial interRAI assessments were not completed within 21 days of admission for one rest home resident.  (ii) Initial long-term care plans were not completed within 21 days of admission for three (two hospital and one rest home) files reviewed.  (iii) Follow-up interRAI assessments were not completed at least six monthly for one hospital resident. | (i)-(iii) Ensure all interRAI assessments, care plans and evaluations are completed within contractual timeframes.  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | Long-term care plans were documented by the registered nurse. All residents had a long-term care plan in place. Caregivers were knowledgeable about the individual resident care needs. The care plans documented the resident health conditions; however, it was not always clear what interventions were current and what was obsolete, and this continues to be an area requiring improvement. | Three of six care plans (one rest home and two hospital) had been updated; however obsolete interventions had not always been crossed and signed out as resolved or not current. | Ensure that care plans contain up-to-date information and obsolete interventions are crossed out.  60 days |
| 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. | PA Low | Staff were evidenced to be caring and attentive to residents with resident and family members agreeing that caregivers were kind and caring. Monitoring of residents to ensure their safe and effective care was not always documented or implemented. | (i) Two hourly position changes were not evidenced as implemented for one hospital resident.  (ii) Two hourly monitoring charts at night and intentional rounding day checks were not documented for one rest home resident as per care plan instructions.  (iii) Routine monthly observations and weight were not documented for May or June for a hospital resident. | (i)-(iii) Ensure monitoring is implemented according to documented care plan interventions.  60 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

|  |
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| No data to display |

End of the report.