

Tairua Residential Care Limited - Tairua Residential Care

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:	Tairua Residential Care Limited
Premises audited:	Tairua Residential Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 December 2019 End date: 12 December 2019
Proposed changes to current services (if any):	Nil
Total beds occupied across all premises included in the audit on the first day of the audit:	42

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

Tairua Residential Care can provide care for up to 44 residents requiring either rest home or hospital (medical or geriatric) level of care. On the day of the audit, there were 42 residents in total.

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 general manager is a registered nurse and is responsible for the clinical and operational management of the service along with a team of registered nurses.

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

Three of the five shortfalls identified as part of the audit have been addressed. These were around family communication, recruitment documentation and assessments. There continues to be shortfalls around timeliness of initial interRAI assessments and care plan interventions.

This audit has identified further areas requiring improvement around essential notifications, orientation, appraisals, medication management, food safety management, and wound care documentation.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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There is a business, quality and risk management plan in place which defines the scope, direction and objectives of the service and the monitoring and reporting processes. The service is managed by the general manager who is a registered nurse with a current practising certificate.

The framework around a quality and risk management system is documented. There are a range of policies and forms in place to guide practice. Quality outcomes data is collected with a process in place to record adverse events.

The human resource management system is documented.

There is a documented rationale for determining staff levels and staff mix in order to provide safe service delivery in the rest home and hospital. An appropriate number of skilled and experienced staff are allocated each shift with a full complement of registered nurses now in place.

Resident information is stored securely.

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 nurses are responsible for each stage of service provision. The registered nurses assess, plan and review residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and are evaluated at least six monthly. Resident files include medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurses and caregivers are responsible for administration of medicines and complete annual education and medication competencies.

The activity team provide and implement an interesting and varied activity programme. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. Residents with additional requirements/modified needs were being met.

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 holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised. Documented systems are in place for essential, emergency and security services.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were nine residents using restraints and one with an enabler at the time of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Information obtained through surveillance is used to determine infection control activities and education needs within the facility.

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	4	0	0
Criteria	0	36	0	3	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints management policy and procedure is documented and follows Right 10 of the Code. The complaints policy and procedure are explained by the staff as part of the admission process.</p> <p>There are complaint forms available at the main entrance to the building. The general manager manages resident complaints. A resident complaints register is maintained as part of the Towards Improving Services (TIS) register. There have been no complaints since the previous audit.</p> <p>Family and five residents (three rest home and two hospital) interviewed, stated that they have not had to complain formally, but stated that any suggestions are treated seriously, with improvements when appropriate. Staff interviewed; one cook, one diversional therapist, four caregivers, and two registered nurses (RN) were able to describe the complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The general manager, who is a registered nurse, confirmed family are kept informed. Relatives (two hospital and three rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Two monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Seven 'Towards Improving Services' forms (TIS - accident/incident forms) reviewed, evidenced relatives are informed of any</p>

<p>provide an environment conducive to effective communication.</p>		<p>incidents/accidents, this is an improvement from the previous audit. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>The general practitioner interviewed, reported satisfaction with communication by staff.</p> <p>Interpreting services are available through the district health board. There are no residents requiring the use of interpreting services.</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>Tairua Residential Care has been in operation since April 2011 and is privately owned. The service provides care for up to 44 residents at rest home and hospital level care. There are 32 rest home level beds and 12 hospital level beds. On the day of audit, there were 30 rest home residents (including one on an independent funding contract) and 12 hospital care residents (including one funded through ACC). All other residents were under the age-related residential care services agreement.</p> <p>The philosophy, mission statement and values are documented and known to staff, residents and family members. The mission statement is 'to assist residents, respectfully and with dignity; to safely enjoy life, love and laughter in their own way, time and space'. The service has a business plan, which is reviewed annually. The business plan identifies the purpose, values and scope of the business. The service has quality goals, which have been reviewed regularly. The general manager is a registered nurse who has significant experience in elderly care, she also undertakes the clinical leadership for the service supported by a team of registered nurses.</p> <p>The manager has completed at least eight hours of professional development.</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>FA</p>	<p>The quality and risk management programme identify objectives for the service. A quality plan is documented with goals, accountabilities, timeframes and measures to report against. Monthly staff meetings review quality goals.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff confirmed they are made aware of any new/reviewed policies.</p> <p>Monthly staff meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. The staff interviewed were aware of quality data results, trends and corrective actions.</p> <p>There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at</p>

		<p>meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>The service collects incident and accident data on forms and enters them into a paper-based register. The general manager collates all data and provides a monthly report which is discussed at the monthly staff meetings.</p> <p>Seven TIS forms (incident forms) were reviewed. All forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The general manager collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>One TIS form was related to a fire. The documentation evidenced that all appropriate actions were taken including calling the fire department. The fire was successfully contained. Following the incident, the fire system has been checked to ensure full compliance. A section 31 notification was not completed.</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>	PA Low	<p>There is an established system in place for human resource management.</p> <p>All staff records reviewed included an employment agreement and a position description was on file.</p> <p>Professional qualifications are validated with a current annual practicing certificate on file for registered nurses; the medical officer; physiotherapist and pharmacist. An orientation process is documented, but not all have a documented orientation on file. Performance appraisals have not all been completed for all staff who have been employed for 12 months or more. Of the five staff files reviewed two were for newer staff. Both these staff had documented reference checks and police vetting. This is an improvement from the previous audit.</p> <p>There is a registered nurse in charge on each shift. Files of registered nurses reviewed hold current first aid certificates. Other staff also have a first aid certificate with these including the cook and the diversional therapist. There are seven registered nurses and three have completed interRAI training.</p> <p>There is an annual training plan that is implemented and attended routinely by most staff. Attendance records are kept for each session with documentation of what is covered in each session. Staff stated that they find the training relevant to their roles. Some sessions are facilitated by a registered nurse and at times, there are sessions facilitated by specialists from the district health board or other providers such as Hospice.</p>

		Medicines are given by registered nurses and caregivers who have been assessed as competent. Staff participate in meetings and confirmed that they are kept up to date on changes occurring within the service or matters of concern through handover and open dialogue with the general manager and the clinical nurse manager.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The human resources policy determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RNs and general manager.</p> <p>Hospital wing (12 beds with 12 residents on the day of audit).</p> <p>There is an RN for each shift.</p> <p>AM: There are three caregivers.</p> <p>Rest home wing (32 beds with 30 residents on the day of audit).</p> <p>There is an RN for the AM shift four days a week.</p> <p>AM: There are three caregivers.</p> <p>Rest home and hospital;</p> <p>There are three caregivers for the PM shift with an additional activities' person 10 am to 6 pm for the rest home. There is one caregiver for the night shift.</p> <p>The general manager lives close by and is on call at all times. Staff stated that the general manager responds immediately in the event of an emergency.</p> <p>There is a staff member on duty on each shift, with a current first aid certificate.</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</p>	PA Moderate	<p>The medication management system includes a medication policy and procedure that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. All medicines are stored securely when not in use. However, not all stored medication was within date. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (ie, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior caregivers with medication administration responsibilities. Administration sheets sampled were not all appropriately signed.</p> <p>Ten medication charts reviewed identified that the GP had seen the resident three-monthly. A caregiver was</p>

practice guidelines.		<p>observed administering medications and followed correct procedures.</p> <p>There were no residents self-medicating on the day of audit. Standing orders are not used.</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>	PA Low	<p>All meals at the service are prepared and cooked on site. The kitchen was observed to be clean, but all aspects of food management were not in place. All temperatures were monitored including fridges, freezer and meals on serving. The menu had been reviewed by a dietitian in 2018. The service does not currently have an approved food control plan. The service advised that they have applied for the assessment. Kitchen staff have been trained in safe food handling. Staff were observed delivering meals and assisting residents with their lunchtime meals as required. Diets were modified as required. Resident dietary profiles and likes and dislikes were known to food services staff and any changes were communicated to the kitchen via the registered nurse. Resident meetings and surveys allowed for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicated satisfaction with the food service. Alternatives are offered for dislikes.</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>The RN completes an initial assessment and care plan on admission, including a clinical risk assessment and relevant risk assessment tools (link to 1.3.3.3 for timeliness of interRAI assessments). Resident needs and supports were identified through available information such as discharge summaries, medical notes and in consultation with significant others. All resident files reviewed had a current interRAI assessment and care plan. This is an improvement from the previous audit. There were no respite residents on the day of audit.</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>Long-term care plans evidenced resident and family/whānau involvement in the care plan process. Relatives interviewed confirmed they are involved in the care planning process. Resident files demonstrated service integration. Discussion with relatives and observation on the day of audit confirmed that care is appropriate for resident needs and provided in a timely and caring manner. There was evidence of allied health care professionals involved in the care of the resident including: physiotherapist, podiatrist, and dietitian, wound care nurse specialist and older person's mental health services.</p> <p>Resident care plans reviewed did not include all care and support as documented in interRAI assessments, progress notes or other assessments. Short-term care plans are used for changes to health status and sighted in resident files but were medically oriented and did not include specific nursing care. Care plan interventions to meet all assessed needs is a continued shortfall from the previous audit. Handovers evidenced that in-depth resident</p>

		information is discussed to ensure safe care.
<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>	PA Moderate	<p>There is documented evidence in the progress notes of family/whānau contact in each resident file that indicates family were involved in care planning. Discussions with families confirmed they are aware of the care and support provided. The GP confirmed on interview that care interventions are appropriate and that GP instruction is implemented.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. The service had fourteen wounds logged onto the register this included; skin tears, a healing ulcer and five pressure injuries. Wound care documentation and timeliness for wound dressings are an area for improvement. There is evidence of the wound nurse specialist involvement in wound management.</p> <p>Continence products are identified in resident files and include a urinary continence assessment, bowel management, and continence products identified. There is access to a continence nurse specialist by referral. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring forms are used for weight, vital signs, blood sugar levels, pain, challenging behaviour, food and fluid charts.</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>	FA	<p>The service currently employs one diversional therapist and activity coordinator and two part-time support activities staff members. The programme is planned monthly and activities planned on the day were displayed on noticeboards around the facility. Resident files included a personalised activities assessment and plan. The programme is Monday to Friday and integrated to meet the physical and psychosocial wellbeing of the residents. The programme includes; outdoor garden activities, including garden walks, poetry reading, exercises for both the less mobile and the more active, a daily walking group (volunteers assist so that residents in wheelchairs can come along). There are regular outings into the community. The service has a van for regular outings. One-on-one activities such as individual walks, reading and chats and hand massage occur for residents who choose not to be involved in group activities. Themes and events are celebrated.</p> <p>An activities resident profile is completed on admission. Individual activity plans were seen in long-term resident files. The activity team is involved in the six-monthly review with the RN. The service receives feedback and suggestions for the programme through monthly resident meetings and direct feedback from residents and families. Residents and families interviewed said the activities programme was very good.</p>
<p>Standard 1.3.8: Evaluation</p>	FA	<p>Written evaluations are undertaken using the interRAI tool or updated through the care plan process. The GP reviews the residents at least three monthly or earlier if required. The ACC resident had documented evaluation</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>though the ACC team. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.</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 service displays a current building warrant of fitness, which expires on 23 September 2020. The service employs a maintenance person. Daily maintenance requests are addressed. There is an annual maintenance plan, which includes six monthly building compliance checks, (eg, hot water temperature, call bells, resident equipment and safety checks). Medical equipment and electrical appliances have been tested and tagged and calibrated. Essential contractors are available 24-hours. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and courtyards on the ground floor. There is a designated outdoor smoking area. Seating and shade are provided.</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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is reported at the monthly staff meetings. Data and graphs of infection events are available to staff. Trends are identified, analysed and preventative measures put in place.</p> <p>Systems in place are appropriate to the size and complexity of the facility, there have been no outbreaks in the last 12 months.</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>There is a policy around use of enablers and restraint. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is documented. There is one resident with bedrail enablers at the service and nine residents using bedrail restraint at time of audit.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. One resident record was reviewed for a resident using an enabler and one for a restraint. Both care plans included an assessment and the care plan referred to the use of the enabler or restraint.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	<p>Towards improving services, forms are completed and followed up. One incident form documented a fire in a resident room. All appropriate actions were taken at the time and follow up included a review of the fire safety system. Notification to the ministry of health was not completed.</p>	<p>A fire in a resident room was not notified to the ministry of health.</p>	<p>Ensure that essential notifications are completed and sent.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the</p>	PA Low	<p>There is a documented process for the orientation and induction of all new staff. Of the five staff files reviewed, two were for new staff, one did not have a documented orientation on file.</p>	<p>One new caregiver did not have a documented orientation on file.</p>	<p>Ensure that all new staff receive a documented orientation when first employed at the service.</p>

service provided.				90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	The service has policies and procedures in place around human resource practices, including the need for an annual appraisal for all staff. Not all staff have a documented appraisal on file.	Of the five staff files reviewed, four had been employed over a year. Three of the files for staff employed over a year did not have an up to date appraisal documented.	<p>Ensure that staff have a documented annual appraisal as per policy.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	Policies are in place to safely manage medication storage and prescribing and administration. GPs prescribe all medications. Medication charts included the date started for all medications and stopped where relevant. All charts sampled were legible and had been reviewed three-monthly. Not all stored medications were within date and not all medication had been signed for on administration.	(i). The medication cupboard contained out-of-date medication. (ii). Two of ten medication charts reviewed included instances of medication not signed for on administration.	<p>(i). Ensure that medications are within date. (ii). Ensure that all medications are signed for on administration.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Moderate	The kitchen was observed to be clean and meals well presented. The service has applied for a food control plan assessment and this has yet to be completed. Not all aspects of food control and kitchen management were being implemented.	(i): Food temperatures were not monitored and recorded. (ii). Bulk food was not all dated and labelled in the larder, not all food was dated and labelled in the chiller and food was not all dated on opening. (iii). Bins in the kitchen had no lid. (iv). Food control plan has not been verified.	<p>(i). Ensure temperatures are monitored and documented. (ii) Ensure food is dated and labelled; (iii) Ensure bins are covered; (iv). Ensure the food control plan is verified.</p>

				90 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The service has three interRAI trained staff. New residents have not all had the initial interRAI assessment within timeframes. Ongoing interRAI assessments have been completed six monthly or sooner if a significant change in condition.</p>	<p>Initial interRAI assessments have not been documented according to set timeframes for one rest home and one hospital level residents' files reviewed.</p>	<p>Ensure the initial interRAI assessments are documented according to set timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>All five resident files reviewed have a documented care plan in place. Care staff interviewed were very knowledgeable regarding care and support needs for the residents. Both residents and relatives felt that the care was very good. Care interventions were not documented for all aspects of care including assessed needs.</p>	<p>(i). Interventions to manage identified behaviours that challenge for one rest home and one hospital level care resident were not well documented. (ii). One rest home resident did not have interventions to reflect MRSA colonisation of a wound. (iii). One hospital level resident had falls reflected in the care plan, but interventions to minimise falls were not well documented. (iv). One resident has a short-term care plan in place for a urinary tract infection, however the plan only included the medical aspects of care (antibiotics), not any nursing interventions.</p>	<p>Ensure that care plans reflect resident need and provide care interventions to manage care.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>There are policies, procedures and templates in place for the documentation of wound management. Links to wound specialists were documented as needed and all residents with a pressure injury had nutrition considered as part of care planning. Wound care documentation was identified as an area for</p>	<p>(i). One resident with two pressure injuries had one wound assessment, plan, and evaluation for the both of them (ii). One identified pressure injury that had previously healed, and had broken down again had no current wound care plan (iii). The timeframes for dressings and the time when dressing had been undertaken was inconsistently documented. Staff were able to</p>	<p>(i). Ensure that there is a care plan for each wound. (ii). Ensure that all identified wounds have a current management plan. (iii). Ensure that the timeframes for</p>

		improvement.	explain when dressing should be undertaken, but this was not clear in the wound plans.	dressings/evaluations are documented along with the date of the intervention. 60 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.