

# Archer Care Facility Limited - Archer Village

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## Introduction

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

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

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

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

The specifics of this audit included:

|   |  |
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| <b>Legal entity:</b>  | Archer Care Facility Limited                                 |
| <b>Premises audited:</b>  | Archer Village   |
| <b>Services audited:</b>  | Rest home care (excluding dementia care)                     |
| <b>Dates of audit:</b>  | Start date: 29 September 2017    End date: 29 September 2017 |
| <b>Proposed changes to current services (if any):</b>   | None   |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 53   |

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

| Indicator   | Description   | Definition   |
|---|---|--|
|   | Includes commendable elements above the required levels of performance  | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls  | Standards applicable to this service fully attained                                  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk         |

| Indicator | Description  | Definition  |
|-----------|--|---|
|           | 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

Archer Care is part of the Archer Memorial Baptist Home Trust and is certified to provide rest home level care for up to 55 residents. On the day of audit there were 53 residents. The general manager oversees the operations of the retirement village and care centre. The care centre is managed by a site/quality manager with support from a clinical nurse manager.

This unannounced 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 a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The service has addressed four of seven findings from the certification audit regarding; hazard management, essential notifications, medication documentation.

There continues to be improvements required around registered nurse follow-up, interventions, and implementation of care.

This surveillance audit identified further improvements required around incident forms, staff files, registered nursing reviews and care plan evaluations.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |
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The staff at Archer Care strive to ensure that care is provided in a way that focuses on the individual and residents' autonomy is valued. Information about the Code of Rights and services is easily accessible to residents and families. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |
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The general manager oversees the operations of the retirement village and care centre. The care centre is managed by a site/quality manager with support from a clinical nurse manager and care staff. Quality activities are conducted to identify improvements in practice and service delivery. Health and safety policies are implemented to manage risk. Staff advised that there is an orientation programme that provides new staff with relevant information for safe work practice. The in-service training calendar for 2017 is being implemented. A roster provides sufficient shifts to cover for the delivery of care and support to rest home residents.

## Continuum of service delivery

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| <p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p> |  | <p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p> |
|---|--|---|

The clinical nurse manager takes primary responsibility for managing entry to the service with assistance from the quality/site manager. Comprehensive service information is available. The registered nurses complete care plans and evaluations within the required timeframes. All residents are assessed using the interRAI assessment tool. Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medicines are stored appropriately, and the service has medication policies that comply with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. Meals are prepared on-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Residents interviewed were complimentary about the food service.

## Safe and appropriate environment

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

## 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. |
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There is a restraint policy that includes the provision of a restraint-free environment. There are currently no residents requiring restraints and no 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. 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 13                  | 0  | 3                                    | 3  | 0                                      | 0  |
| <b>Criteria</b>   | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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  |
|---|-------------------|---|
| Standard 1.1.13:<br>Complaints Management<br><br>The right of the consumer to make a complaint is understood, respected, and upheld.                              | FA                | All staff interviewed were able to describe the process around reporting complaints.  |
| Standard 1.1.9:<br>Communication<br><br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA                | There are appropriate policies and procedures to ensure that staff adequately communicate with residents and families. Twelve incident forms reviewed showed that family notification is not always completed or a reason for this is not recorded (link 1.2.4.3). One family member interviewed confirmed that they were not always informed when their family member's health status changes. Five residents interviewed stated that they were welcomed on entry and were given time and explanation about the services and procedures. There is a resident's handbook which provides a guide for living at Archer Care. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. |
| Standard 1.2.1:   | FA                | Archer Care is part of the Archer Memorial Baptist Home Trust. The care centre provides rest home level care to up to 55 residents. On the day of audit there were 53 residents, including two residents on respite.  |



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| <p><b>Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>   |        | <p>Permanent residents were all under the age related residential care (ARRC) contract.</p> <p>The general manager reports to the board on a monthly basis. The service has a current 2017/2018 strategic/business plan and a quality and risk management programme. An annual 2017 quality plan is being implemented. Progress toward previous goals has been monitored and is documented monthly in the general manager's report.</p> <p>The general manager oversees the operations of the retirement village and care centre. The site/quality manager oversees the care centre and reports to the general manager. The site/quality manager has been with the service for ten years. She is supported by a clinical nurse manager who has been in the position for six months, she has over 20 years of experience within the aged care industry. An RN is being employed at the end of October 2017 to help the clinical nurse manager.</p> <p>The site/quality manager has completed more than eight hours of training in the last year relating to the management of a rest home.</p>   |
| <p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | FA     | <p>The quality programme includes the service philosophy, general objectives and lists the quality activities. An annual quality plan for 2017 has been developed and is being implemented. An internal audit schedule is being completed for 2017. Corrective actions have been developed where compliance is less than expected. This is evidenced in the meeting minutes reviewed for staff, quality/health and safety/infection control and resident meetings. Quality meetings evidence discussion of quality activities. Resident meetings are held bi-monthly with follow-up of issues and discussions are completed. An annual resident and relative survey was conducted, with respondents advising that they are overall very satisfied with the care that residents receive. Issues identified in the survey have been addressed with corrective actions implemented.</p> <p>The service collects information on resident incidents and accidents as well as staff incidents/accidents (link 1.2.4.3). The service has a health and safety management system and hazard registers are documented for each area of service. The service maintained their tertiary level ACC workplace safety management practices programme to June 2018. There are procedures to guide staff in managing clinical and non-clinical emergencies. Falls prevention strategies are implemented. There is a list of residents who use hot water bottles (one resident on the day of the audit). This information is recorded in their care plans, including the associated risks of using hot water bottles. This previous finding has been addressed.</p> |
| <p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are</p>  | PA Low | <p>There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the RN. Analysis of incident trends is conducted by the site/quality manager. There is a discussion of incidents/accidents at quality and staff meetings. A sample of twelve incident/accident forms reviewed for August and September 2017 had been commenced by either the registered nurse (RN) or the healthcare</p>   |

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| <p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>   |               | <p>assistants (HCA). Progress notes reviewed for a sample of resident's evidence that incidents and accidents have been reported. Follow-up by an RN is evident in the resident incident forms reviewed (link 1.3.3.4); however, not all forms had notification to the next of kin and not all neurological observations were completed for unwitnessed resident falls that resulted in a potential head injury.</p> <p>The management team are aware of their requirement to notify relevant authorities in relation to essential notifications. Advised there have been no adverse events since the last audit that would have triggered a section 31 notification. The service notified public health in relation to two outbreaks that occurred in November and December 2016. The previous finding has been addressed.</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 Low</p> | <p>There are human resources management policies in place which includes a recruitment and staff selection process that requires relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept.</p> <p>The service has in place an orientation programme that provides new staff with relevant information for safe work practice. Staff were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Five staff files were reviewed (one clinical nurse manager, one enrolled nurse, two home assistants and one cook) and evidence that reference checks are completed before employment is offered. All files reviewed evidenced signed job descriptions, however, orientation checklists, up-to-date annual performance appraisals and reference checks were not all evident in the five staff files reviewed.</p> <p>The in-service training calendar for 2017 is being implemented. Discussion with the training coordinator and records reviewed confirms that an in-service training programme has been provided. Annual training days are provided for staff to attend.</p> |
| <p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>       | <p>FA</p>     | <p>The staffing policy includes staff rationale and skill mix. The site/quality manager and the clinical nurse manager both work full time from Monday to Friday. An RN is being employed at the end of October 2017 to help the clinical nurse manager. Two enrolled nurses are also employed. The site/quality manager is on call for any operational issues and the clinical nurse manager covers the on call for any clinical concerns. There is at least one staff member on each duty with a first aid certificate.</p> <p>There are five healthcare assistants (HCAs) on duty on the morning shift, three HCAs on duty on the afternoon shift and two HCAs on the night shift. There is a staff workload monitoring policy, which takes the acuity of residents into consideration when determining staff numbers on duty. Residents and the relative interviewed confirm that there are sufficient staff on-site at all times and staff are approachable and in their opinion, competent, professional, respectful and friendly.</p>   |

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|   |    | Four healthcare assistants interviewed stated there was sufficient staff to provide care and RNs were available when needed.   |
| <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>        | FA | <p>Ten medication charts were reviewed. The medication management policies and procedures comply with medication legislation and guidelines. An electronic medication management system is in place for regular medication. Paper based charts were being used for the prescribing of Warfarin. Warfarin had been prescribed correctly and Warfarin was being administered as prescribed. This was a previous finding that has been addressed. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Residents' medicines are stored securely in the medication room/cupboard.</p> <p>Registered nurses, enrolled nurses and HCAs administer medicines. All staff that administer medicines are competent and have received medication management training. Medication administration practice complied with the medication management policy for the medication round sighted. The facility uses a blister packed medication management system for the packaging of all tablets. The enrolled nurse on duty reconciles the delivery and documents this. There was evidence of three-monthly reviews by the GP. Medication administration records showed that all medications were administered as prescribed. On the day of audit all residents self-administering medicines had documentation correctly recorded and a competency assessment completed. There were no standing orders in use.</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> | FA | <p>There is a fully functional kitchen and all food is cooked on-site by the dedicated kitchen staff. There is a four-weekly rotating seasonal menu, which has been reviewed in September 2017 by an external dietitian. The food service is HACCP certified annually. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. Archer has moved to self-service via a buffet to enable residents to 'choose' what they want to eat at each meal.</p> <p>The kitchen is able to meet the needs of residents who require special diets and the hospitality supervisor works closely with the RNs. Special diets and resident individual likes and dislikes are accommodated. The kitchen staff have completed food safety training. 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. Residents and the family member interviewed were very happy with the quality and variety of food served.</p>   |
| Standard 1.3.4:   | FA | Files sampled indicated that personal needs information is gathered during admission in consultation with the resident and their family/whānau where appropriate (link 1.3.5.2). The interRAI and 'as required' additional   |

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| <p>Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>   |                        | <p>nutritional, pain, and falls assessment tools were in use. The interRAI assessment tool was used to develop the long-term care plan (link 1.3.5.2) and to review the resident at least six-monthly or when there was a change to a resident's level of care. InterRAI assessments have been completed for four of five residents' files reviewed. One resident was a respite resident and did not require an interRAI. The previous shortfall has been addressed.</p>  |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>                       | <p>PA<br/>Moderate</p> | <p>The service is using the interRAI long-term care plan template. All resident files reviewed contained a care plan. Initial and long-term care plans reviewed did not always describe the support required to meet the resident's goals and identified care needs. Short-term care plans were not evidenced for all acute changes in health status. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. The previous shortfall has not yet been addressed.</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<br/>Moderate</p> | <p>Registered nurses and HCAs follow the care plan (link 1.3.5.2) and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RNs will initiate a referral (e.g., to the district nurse, hospice nurse or wound specialist nurses). If external medical advice is required, this will be actioned by the GPs. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are available. Specialist continence advice is available as needed and this could be described.</p> <p>Wound assessment, monitoring and wound management plans are in place. Not all wound documentation has been fully completed. On the day of audit there were four residents with six wounds. This includes one resident with three chronic wounds, one abrasion, one lesion, and one skin tear. There were no pressure injuries. The RNs have access to specialist nursing wound care management advice through the district nursing service. The GPs practise nurse was managing the care of one resident with three wounds.</p> <p>Interviews with the clinical nurse manager, enrolled nurse, and home assistants demonstrated an understanding of the individualised needs of residents. Care plans reviewed did not include interventions to support all residents' assessed needs (link 1.3.5.2). There was evidence of blood sugar monitoring charts and weight monitoring charts in use. One file reviewed of a resident weight loss was reviewed by the GP. The GP documented that the resident did not require additional interventions at this time and to continue with monthly weighs. There is evidence of regular and consistent monitoring of elimination needs by the RNs. The previous shortfalls have been addressed, however the criterion continues to remain a finding as there were shortfalls around wound care documentation.</p> |

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| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p>     | <p>The service has achieved the seven Eden principles. The programme meets the recreational needs of the rest home level care residents and reflects normal patterns of life. The programme is supported by a team of volunteers. At least 40 hours per week of the resident's recreational programme are resident or volunteer lead. The service employs two social and event coordinators who work a total of 65 hours per week. The weekend programme is delivered by care staff and volunteers. There is a set activity programme that is resident-focused and is planned around meaningful everyday activities such as gardening, swimming, exercises, kindergarten visits, reminiscing, knitting groups, church services, bowls, golden oldies mission supporting and fundraising for Fiji.</p> <p>There is a well-established community programme in place with weekly resident visits to assist at a local school. There is evidence that the residents have input into review of the wider programme (via Eden circles and resident meetings) and this feedback is considered in the development of the resident's activity programme. Residents interviewed expressed satisfaction with the programme. An activity profile is completed on admission in consultation with the resident/family (as appropriate). The documentation in the resident files reflected the specific needs and interests of each resident. Relatives and residents interviewed advised that the activity programme was interesting, and the residents were encouraged to participate. In the files reviewed the recreational plans had been reviewed six-monthly. Activity participation was noted.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | <p>PA Low</p> | <p>The RNs evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that a new long-term care plan was rewritten every six months and changes made as required at this time, but evaluations were not documented. There was at least a three-monthly review by the GP. Not all changes in health status were documented and followed-up (link 1.3.3.4 and 1.3.5.2). Reassessments are completed using interRAI LTCF for all residents who have had a significant change in health status. 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 (link 1.3.5.2). Where progress is different from expected, the service does not always respond by initiating changes to the care plan (link 1.3.5.2).</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</p>   | <p>FA</p>     | <p>Archer Care has a current building warrant of fitness certificate which expires on 1 February 2018.</p>  |

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| purpose.  |    |  |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>                                       | FA | <p>There were emergency/disaster management plans in place to guide staff in managing emergencies and disasters. There was an emergency/disaster management manual available for staff, residents and visitors in the event of specific emergencies/disasters (including fire, earthquakes, floods, storms, Tsunami and gas leaks).</p>  |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p> | FA | <p>Infection surveillance is an integral part of the infection control programme and is described in the Archer Care infection control and surveillance 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 is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly quality meetings, and monthly staff meetings. If there is an emergent issue, it is acted upon in a timely manner. There have been two outbreaks in November and December 2016.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  | FA | <p>The service has documented systems in place to ensure the use of restraint is actively minimised and provides a no restraint environment. There were no residents with restraint and no residents with an enabler. Staff interviews, and staff records evidence guidance has been given on restraint minimisation.</p>  |

## Specific results for criterion where corrective actions are required

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

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

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

| Criterion with desired outcome  | Attainment Rating | Audit Evidence  | Audit Finding  | Corrective action required and timeframe for completion (days)  |
|---|-------------------|---|--|---|
| <p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p> | PA Low            | <p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Twelve accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. However, not all forms had notification to the next of kin and not all neurological observations were completed for resident falls that resulted in a potential head injury.</p> | <p>Twelve incident forms were reviewed in total. (i) Five of twelve incident forms reviewed did not have documented evidence of notification to the next of kin. (ii) Five incident forms were reviewed for unwitnessed resident falls with a head injury. The neurological observations forms completed were not all fully completed.</p> | <p>(i)Ensure incident forms reflect NOK are notified unless requested otherwise; (ii) Ensure that neurological observations are documented and completed for any resident fall with a potential head injury.</p> <p>90 days</p> |

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| <p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>                         | <p>PA Low</p>      | <p>There are human resource management policies in place. This includes that the recruitment and staff selection process require that relevant checks be completed to validate the individual's qualifications, experience and veracity. However, orientation checklists, up-to-date annual performance appraisal and reference checks were not all evident in the five staff files reviewed.</p>  | <p>Two of five staff files did not include an orientation checklist, three of five staff files did not have an up-to-date annual performance appraisal and four of five staff files did not include reference checks.</p>   | <p>Ensure that all staff files have an orientation checklist, an up-to-date annual performance appraisal on file and that reference checks are completed</p> <p>90 days</p> |
| <p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>                    | <p>PA Moderate</p> | <p>Handovers are completed at the commencement of shifts. The registered and enrolled nurses are responsible for all aspects of clinical assessment and care planning. Healthcare assistants and RNs document in progress notes. There were examples sighted in progress notes where assessments had been completed by a RN in response to changes in health status. Residents who had experienced an adverse event were not always followed up or reviewed by a RN in a timely manner and this remains an improvement required from previous audit.</p> | <p>The review of residents following adverse events was not completed in a timely manner for three resident incident forms sampled.</p>   | <p>Ensure that the RNs review and follow-up all clinical issues in a timely manner.</p> <p>30 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>The RNs are responsible for the development of the care plans. Information gathered during admission was not reflected in the initial care plan in all files sampled. Not all information gathered through the use of the interRAI was transferred to the long-term care plan. Short-term care plans were in use but not for all changes in health conditions. This previous finding remains an area for improvement.</p>   | <p>(i) Two of five initial care plans reviewed (including the respite resident) lacked sufficient detail to guide the care staff with the management of continence and severe depression.</p> <p>(ii) One of five residents with an acute change in health condition did not have short-term care plans documented or where they were</p> | <p>i-iii) Ensure that interventions are documented for all assessed care needs and the interventions documented include sufficient detail to guide the care staff.</p>      |



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|   |             |  | <p>documented, they lacked sufficient detail to guide the care staff with the management of fluid restriction.</p> <p>(iii) Two of five residents long-term care plans did not have interventions documented in sufficient detail to guide the care staff in the management of continence</p>              | 60 days   |
| <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> | PA Moderate | <p>The EN with RN oversight, documents wound management plans for all residents with wounds, however documentation was not fully completed. Wounds are dressed by the enrolled nurse, RN or HCAs.</p> <p>Interviews and monitoring charts sampled indicated that resident's needs are being met. There was evidence of blood sugar monitoring charts and weight monitoring charts in use. One file reviewed of a resident with dietitian input following weight loss had interventions documented to manage the weight loss and weight monitoring and food input charts were being completed. There is evidence of regular and consistent monitoring of elimination needs by the RNs. These previous shortfalls have been addressed, however the criterion continues to remain a finding as there were shortfalls around wound care documentation.</p> | <p>(i) Three of six wounds reviewed had incomplete assessments documented. The other three wounds did not have assessments documented. (ii) Five of six wounds management plans were not fully documented. (iii) Three of six wounds managed at the facility did not consistently document evaluation.</p> | <p>i-iii) Ensure all wounds have a comprehensive assessment and management plan and regular evaluations.</p> <p>60 days</p> |
| <p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or</p>   | PA Low      | <p>A new care plan is completed six-monthly using the interRAI care plan. Evaluation of progress towards meeting care plan goals was not documented for the three care plans requiring this. One resident was a recent admission and one was a respite resident so did not document evaluations.</p>   | <p>Three of three eligible residents long-term care plans did not have evaluations documenting progress towards goals.</p>   | <p>Ensure that all evaluations of long-term care plans document progress towards meeting goals.</p>                         |

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| response to the support and/or intervention, and progress towards meeting the desired outcome. |  |  |  | 90 days |
|--|--|--|--|---------|

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

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

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

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

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End of the report.