

# Residential Management Limited - Terence Kennedy House

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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:

<b>Legal entity:</b>	Residential Management Limited
<b>Premises audited:</b>	Terence Kennedy House
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 11 December 2018    End date: 12 December 2018
<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>	44

# 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
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

Terence Kennedy House provides rest home and hospital level care for up to 45 residents. On the day of the audit there were 44 residents. The service is managed by an experienced manager with support from the general manager and clinical coordinator. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant 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, a general practitioner and staff.

The service has addressed two of three previous shortfalls around corrective actions, and hot water temperatures. There continues to be an improvement required around interventions.

This audit has identified further areas requiring improvement around neurological and storage of chemicals.

## 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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Policies are implemented to support residents' rights, communication and complaints management. Complaints and concerns have been managed and a complaints register is maintained.

## 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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The quality and risk management programme includes service philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes. Residents/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and link to the quality system. A comprehensive education and training programme has been implemented with a current training plan in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and are evaluated at least six-monthly. Resident files included medical notes by the contracted general practitioner, nurse practitioner and visiting allied health professionals.

Medication policies reflect guidelines. Medication charts are reviewed three-monthly by the general practitioner.

The activities coordinator implements the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings and celebrations. Residents and families reported satisfaction with the activities programme.

## Safe and appropriate environment

<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>Some standards applicable to this service partially attained and of low risk.</p>
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The building has a current warrant of fitness. There is sufficient space to allow the movement of residents around the facility using mobility aids.

## 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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Terrence Kennedy House has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were two residents with restraint and five residents with an enabler. Restraint management processes are adhered to.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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A surveillance programme is documented and undertaken, and this is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

## 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	12	0	3	2	0	0
<b>Criteria</b>	0	38	0	3	2	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of complaints process. There are complaint forms available. Information about complaints is provided on admission. Interviews with residents demonstrated an understanding of the complaints process.</p> <p>Staff were interviewed around their knowledge of the complaints process. These included five healthcare assistants, a registered nurse, clinical coordinator, physiotherapist, hospital manager, general manager, activities coordinator, laundry assistant, cook and nurse practitioner. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. Verbal and written complaints are documented. Two complaints managed by the hospital manager were reviewed and all have been resolved in a timely manner as per the policy with confirmation from the complainant that they were happy with the outcome.</p> <p>There have been four complaints from external authorities (district health board and Health and Disability Commission) that have been raised since the previous audit and one that was raised by an external authority prior to the previous audit, but with actions still ongoing during the timeframe to the current audit. Four of the five have been closed by the external authority with written confirmation of this sighted. One has been addressed within timeframes requested, however the external authority has asked for some additional information.</p> <p>Discussions with residents and relatives confirmed that any issues are addressed, and they feel comfortable</p>



		to bring up any concerns. Three interviewed stated that they had raised a concern, and all noted that these had been addressed promptly to their satisfaction.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies are documented to guide effective communication with residents and family. These include the incident, complaints and open disclosure policies and procedures. The clinical coordinator, the hospital manager or registered nurses notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Fifteen incidents/accidents forms were reviewed. The forms included a section to record family notification. All forms indicated family were informed.</p> <p>Relatives interviewed (three with family requiring hospital level care) confirmed that they are notified of any changes in their family member's health status. They also stated they were welcomed on entry and were given time and explanation about the services and procedures.</p> <p>Residents interviewed (eight interviewed including one from the hospital who is identified as being under 65 years of age, and two from the rest home) stated that they received information around their care from the registered nurses and were kept informed of any changes in the service through the resident meetings.</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>	FA	<p>Terence Kennedy House is a facility located in West Auckland that provides 45 dual-purpose rest home and hospital level beds. On the day of the audit there were 44 residents including eight residents requiring rest home level care and 36 requiring hospital level care. Two of the hospital residents are identified as under 65 years of age – one under a young person with a disability and one under a contract for long-term chronic care. Two of the hospital residents have been admitted under an Accident Compensation Corporation contract. There were no residents requiring respite care.</p> <p>A business plan is in place for 2018 with one also developed for 2019. These are reviewed at regular intervals throughout the year by the management team. A mission, philosophy and objectives are documented for the service. The manager completes a weekly report for the general manager and then meets at least weekly to review the day-to-day operations and to review progress towards meeting the business objectives.</p> <p>The hospital manager has 30 years of management experience in the aged care sector and has been in the role for two years. The hospital manager has extensive experience in management in other facilities and has a Diploma of Business. The hospital manager is supported by a clinical coordinator who is a registered nurse. The clinical coordinator has been in the role for seven months and has been in the aged care sector for two years. The hospital manager is also supported by a non-clinical general manager (one of three directors) who also provides support for a sister site. The hospital manager has maintained a minimum of eight hours of professional development relating to managing an aged care service.</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>A quality and risk management programme is in place. This includes a quality and safety plan for the service with goals focused on enhancing patient safety, improving systems and processes, improving resident and family engagement and optimising the resident experience. Interviews with the general manager, hospital manager and staff, indicated that there is a sound understanding of the quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are purchased from an external consultant with these reviewed in 2018. Policies and procedures have been updated to include reference to interRAI, health and safety and pressure injury management. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are expected to sign that they have read the new/revised policies. A document control system is in place.</p> <p>Quality management systems are in place including: internal audits; incident and accident reporting; health and safety reporting; infection control data; and complaints management. Data is being collected monthly and is consistently communicated to staff through meetings. Meetings held include the following: monthly staff meetings that includes discussion of all aspects of the quality programme; quality review meeting that includes the general manager, hospital coordinators (from this and a sister site) two to three monthly; a management meeting that includes the hospital managers, general manager, operations manager, legal counsel and village manager monthly; two weekly registered nurse meetings facilitated by the clinical coordinator and monthly resident meetings.</p> <p>Corrective actions are consistently documented, reviewed and communicated to staff with evidence of resolution documented. Results of internal audits are now communicated to staff through meetings with evidence of discussion. The corrective action identified at the previous audit has been addressed.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the hospital manager and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are</p>	<p>PA Low</p>	<p>There is an accidents and incidents reporting policy. The hospital manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings. A registered nurse conducts clinical follow-up of residents.</p> <p>Fifteen incident forms sampled from October 2018, included review of the incident by the clinical coordinator,</p>

<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>however not all neurological observations were completed for a significant length of time.</p> <p>Discussions with the general manager, hospital manager and clinical coordinator confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Section 31 forms have been completed for pressure injuries and for the appointment of the new clinical coordinator.</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>FA</p>	<p>There are human resources management policies in place and managers are aware of how the policies are to be implemented. Annual practicing certificates are in place for all health professionals including registered nurses, the nurse practitioner, pharmacy staff, dietitian, physiotherapist and podiatrist.</p> <p>Nine staff files were reviewed (hospital manager, one clinical manager, two registered nurses, one activities coordinator, one cook, one laundry assistant, and two healthcare assistants) and all evidenced that reference checks are completed before employment is offered. Each staff member has a signed contract with evidence of criminal vetting for new staff who have been employed in the last two years.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. This includes a buddy system with two new staff confirming that the programme is comprehensive and includes reading of policies.</p> <p>The in-service education programme for 2018 is implemented, with attendance records maintained and a spreadsheet of staff training updated by the hospital manager. The clinical coordinator and registered nurses can attend external training, including sessions provided by the local district health board. Seven of the eight registered nurses, including the clinical coordinator have completed interRAI training. Nine healthcare assistants have completed level three training, and Careerforce. Annual staff appraisals are completed.</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 policy includes a staffing rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents with all care staff interviewed confirming that there are adequate staff on each shift. The hospital manager is on-site five days a week and is on call after hours. The general manager also visits the facility at least once a week and is available to provide support at any time.</p> <p>There is one clinical coordinator and a registered nurse on a morning shift and one registered nurse on an afternoon and night shift. Numbers of registered nurses can be increased if required.</p> <p>There are seven healthcare assistants (three long shift) on a morning roster and five healthcare assistants on an afternoon shift (two long shift). There are two healthcare assistants overnight. Extra staff can be called in for increased resident requirements.</p> <p>Activities staff are rostered on six days per week. There are separate domestic staff that are responsible for</p>

		<p>cleaning and laundry services.</p> <p>Interviews with staff, residents and family members confirmed that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There is currently one resident self-medicating and they have a competency completed to confirm that they are competent to self-administer medications. Staff described daily checks to ensure that they have taken their medicines.</p> <p>Medications are checked on arrival and any pharmacy errors are recorded and fed back to the supplying pharmacy. Registered nurses and some senior healthcare assistants administer medications. Staff attend annual education around medication. Medication competencies are completed annually and were completed in 2018 around the implementation of medimap. There are standing orders, and these meet legal requirements with review of these completed annually by the NP. The medication fridge temperature is checked daily, and temperatures are within appropriate range as per policy. All medication is stored securely. Eye drops are dated once opened.</p> <p>Staff sign for the administration of medications on medication administration sheets with this including signing by two staff of any administration of controlled drugs. Controlled drugs are kept in a locked safe in a locked room. Balances checked match those recorded in the register. The clinical coordinator has reinstated weekly checks of controlled drugs as this had lapsed while they were on leave. Medications were checked and there was no expired medication.</p> <p>Twelve medication charts were reviewed. Medications are reviewed at least three-monthly by the NP. All medication charts include a photo ID and allergy status. 'As required' medications have indications for use charted.</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>All meals at Terrence Kennedy House are prepared and cooked on-site. There is a four-weekly seasonal menu which has been reviewed by a dietitian within the last two years. Meals are plated in the kitchen and then served in the two dining rooms. End cooked meals and fridge and freezer temperatures are recorded.</p> <p>Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food preferences are met. There is a system to identify residents who require monitoring of food intake. Specialised crockery and utensils are available to help promote independence at meal times.</p> <p>Residents were observed enjoying their lunch in one dining room and a healthcare assistant was observed assisting a resident to eat in another. Residents' meetings allow for the opportunity for resident feedback on</p>

		<p>the meals and food services. Residents are complimentary of the food and confirmed that alternative food choices are offered for dislikes.</p> <p>All staff who work in the kitchen have completed food safety and hygiene and chemical safety training.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans reviewed evidenced multidisciplinary involvement in the care of the resident. Overall, care plans reviewed were resident-centred. Two of five care plans document interventions for each resident as per individual needs. The previous shortfall around interventions continue to be an area for improvement. Residents interviewed stated they are involved in the care planning process.</p> <p>Short-term care plans are in use for changes in health status and have been evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan as needed. There is evidence of service integration with documented input from a range of specialist care professionals including the podiatrist, physiotherapist, dietitian and Mental Health Care Team for Older People. The care staff interviewed advised that the care plans are easy to follow.</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 Moderate</p>	<p>Care plans are in place for all residents. When a resident's condition changes, the RN will initiate a NP consultation. The NP interviewed, confirmed that this occurs in a timely manner. The clinical coordinator and registered nurses stated that they notify family members about any changes in their relative's health status. Care staff interviewed stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>A sample of wounds including the three pressure injuries (for one resident with one stage three and the others unstageable) were reviewed. The wound specialist from the district health board has reviewed the pressure injuries and advice has been implemented. Wound assessment, wound management and evaluation forms are available for all wounds. Wound monitoring occurred as planned.</p> <p>Monitoring forms are in use as applicable such as: weight, vital signs and wounds. Behaviour charts are available for any residents that exhibit challenging behaviour with these completed well on the day of audit. There are gaps in documentation of turns on the turning charts and an improvement is required.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for</p>	<p>FA</p>	<p>There are two activities coordinators who work six days a week for at least five and a half hours a day. There is a monthly large print programme on the noticeboard. Residents have the choice of a variety of activities in which to participate. These include exercises, games, crafts, painting, pet therapy and quizzes. On the days of audit, residents were observed taking part in exercises.</p>

<p>a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat. The activities coordinator may take the residents books, puzzles or crosswords. A volunteer assists the activities coordinator with one-on-one visits.</p> <p>There are fortnightly church services by the Salvation Army and an interdenominational group. Volunteers from the local Catholic Church come weekly to give communion.</p> <p>The facility uses the village van for weekly outings. Every Thursday, a local playgroup visits. There are also regular entertainers visiting the facility. Special events such as birthdays, Easter, Mothers' Day and Anzac Day are celebrated.</p> <p>There is a resident meeting monthly and an annual residents' satisfaction survey. This includes feedback on the activities programme.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career and family. Resident files reviewed identified that the comprehensive individual activity plan is based on this assessment. Activity plans are evaluated at least six-monthly (link 1.3.3.3).</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The six long-term care plans reviewed had been evaluated by the registered nurses six-monthly. Long term care plan evaluations are documented and reflect resident progress. Short term needs had been evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for each resident and these are also evaluated six-monthly. The multidisciplinary review involves the RN, GP and resident/family if they wish to attend. There is at least a three-monthly review by the GP for rest home residents and one-monthly for hospital residents. The family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The building has a current building warrant of fitness. The person responsible for the village maintenance also oversees the reactive and planned maintenance programme for the care facility. All medical and electrical equipment has been recently serviced and/or calibrated.</p> <p>Hot water temperatures are monitored, and all water temperatures in resident areas are below 45 degrees Celsius. The corrective action identified at the previous audit has been addressed.</p> <p>The facility has sufficient space for residents to mobilise using mobility aids. External areas are well maintained. Residents have access to safely designed external areas that have shade. Staff stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. Chemicals are not always locked away.</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 infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. 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 staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraints and enablers. Two hospital residents were using restraint (bedrails) and five hospital residents were using enablers (bedrails) on the day of audit. Assessments are completed, and written consent is provided by the five residents using enablers.</p> <p>Staff interviews confirmed their understanding of the differences between a restraint and an enabler.</p> <p>Staff receive regular training around restraint minimisation and the management of challenging behaviour that begins during their induction to the service.</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>Incident forms are completed by staff when an incident has occurred. Care staff interviewed can describe when they should be writing an incident form and can confirm how incidents are escalated to registered nurses, the clinical coordinator and/or to the hospital manager. The clinical coordinator is aware of and able to describe their responsibilities in reviewing and signing off incident forms. Discussion around incidents is evidenced in relevant meetings.</p> <p>Staff are aware of their obligations around completion of neurological observations if there is an unwitnessed fall or head injury for example. Of the fifteen incident forms reviewed, eight were for an unwitnessed</p>	Neurological observations are not occurring for a sufficient length of time to determine clinical issues.	<p>Complete neurological observations for a sufficient length of time that enables any change in state to be identified.</p> <p>90 days</p>



		fall. All had neurological observations completed, however for seven of the eight incidents, these were only for a short period (ie, for one to three observations only). The policy does indicate length of time for observations to be completed.		
<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>	PA Low	<p>There has been a gap in the past when interRAI assessments have not been completed in a timely manner. The new clinical coordinator has completed the interRAI assessments for residents, however these have been completed after the review of the care plan. The assessment has therefore not been used to inform the care plan.</p> <p>The activities coordinator is completing an assessment and activities plan; however, these are not coordinated to be completed in line with the interRAI and review of the care plan.</p>	<p>(i) InterRAI assessments are being completed after the review of the care plan.</p> <p>(ii) Activities assessments, plans and review are not completed in line with the interRAI and review of care planning.</p>	<p>(i) Ensure that interRAI assessments are completed prior to the review of the care plan.</p> <p>(ii) Complete activities assessments, plans and review in line with the interRAI and review of care planning.</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</p>	PA Moderate	Two of five care plans reviewed included interventions to support all current assessed needs.	Three of five care plans reviewed did not have all interventions fully documented to support all assessed need; (i) one resident with a pressure injury and wounds. However, the care plan did not have any interventions to support wound management and responsibilities of caregivers. (ii) the care plan for one resident who returned from hospital the day before on palliative care had not been updated; (iii) one resident with fragile skin and current wounds did	Ensure interventions are documented or updated to support all current assessed needs.

assessment process.			not have interventions in the care plan to reflect this including links to the wound management plans.	90 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	There are forms in place to monitor interventions. Most, including the wound management and behavioural records, are well documented. The turning charts do not indicate that turns have been given two hourly or as required and there were three charts on the day that stated that the resident had been turned, however the resident was observed to be in the same position, noting that the residents were not able to turn themselves.	Turns (changing resident position) are not always completed two hourly.	<p>Ensure that residents requiring turning at regular intervals are turned with documentation reflecting this.</p> <p>60 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	PA Low	There are two cupboards that have chemicals in them and these are not able to be locked. There was also a dressing trolley on the day of audit that was stated as being left out with some cleaning solution on it. This was put away on the day of audit. The cleaners trolley was left unattended on two occasions with cleaning fluid left on it. There are residents identified in the facility as having a diagnosis of dementia.	Some chemicals are noted to be not locked away at all times.	<p>Ensure that chemicals are locked away or fully supervised when in use.</p> <p>90 days</p>

## 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.

No data to display
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End of the report.