

# Opunake Districts Rest Home Trust - Opunake Cottage Rest Home

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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 Q-Audit 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>	Opunake Districts Rest Home Trust	
<b>Premises audited:</b>	Opunake Cottage Rest Home	
<b>Services audited:</b>	Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 4 February 2019	End date: 4 February 2019
<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>	18	

# 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

The Cottage Rest Home (The Cottage) is a community trust aged care service operated by the Opunake District Rest Home Trust. The Cottage offers rest home level care services for up to 22 residents. The positive feedback regarding the quality of the care and services and the community input and support are strengths of the service. There has been one change to clinical leadership since the last audit.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, families/whānau, one general practitioner, management and staff.

There were eight areas identified as requiring improvement related to essential notifications, residents care plans, meaningful activities, monitoring of fridge temperatures, resident's self-administration of medicines, approval of the evacuation plan, and fire/evacuation training for staff. No other systemic issues were identified.

## 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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Evidence was seen of communication and open disclosure of events in residents' files sampled. Translation services can be accessed through the local DHB if required. Residents and relatives report that they are kept well informed. External reporting requirements are understood.

The Cottage supports the right of residents, family/whānau and visitors to make a complaint. The service has a complaint register and the information is recorded to meet all the requirements of the standard. There were no outstanding complaints at the time of audit.

## 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 organisation's philosophy, mission and vision statements are identified in the strategic plan. The business plan contains quality objectives and risk management strategies.

The service has a facility manager (registered nurse) and a clinical leader with the facility manager being responsible for the overall management of the service. The clinical leader has resigned. A senior registered nurse with relevant experience is acting as the clinical leader until a new appointment is made.

The service has a quality and risk management plan that is appropriate to the size of the facility and level of care provided. Documented policies and procedures are controlled and available to staff. The quality system includes an internal audit process, complaints management, incident/accident reporting, annual resident/family/whanau surveys and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and families/whānau, as appropriate.

Incident and accident management occurs to meet policy requirements including reporting of adverse events to appropriate authorities. Corrective action planning processes are implemented to address issues. Improvement is required in complying with all essential notification requirements.

Staffing levels, skills mix and training meet contractual requirements. Human resources management processes identify good practice and meet legislative requirements.

## 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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Residents' needs are assessed on admission within the required timeframes. Shift handovers and the clinical managers' report guides continuity of care.

Care plans are individualised, based on a range of clinical information. Short term care plans are developed to manage any new problems that might arise. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard.

The planned activity programme is overseen by an activities co-ordinator. Residents are provided with a variety of individual and group activities and residents links with the community is maintained. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies guide food service delivery. The kitchen was well organised. Residents verified overall satisfaction with meals.

## 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.		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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There are documented emergency management response processes which are understood and implemented by staff. Six monthly fire evacuation drills are carried out twice a year but not all staff have attended.

The building has a current building warrant of fitness. The evacuation scheme is appropriate but needs to be approved by the NZ Fire Service. There have been no changes to the facility footprint since the previous audit.

## 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 no restraints and one enabler in use on the day of audit. Policies and procedures are in place to maintain a restraint free environment.

The use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## 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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Surveillance for infection is carried out as specified in the infection control programme. Infection data is collated monthly, analysed and reported. The infection control surveillance and associated activities are appropriate for the size and complexity of the service.

## 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	10	0	3	3	0	0
<b>Criteria</b>	0	33	0	4	4	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<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 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family/whānau stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure.  Staff know how to access interpreter services, though reported this was rarely required due to all residents being able to communicate effectively in English or Te Reo.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Cottage is owned and administered by a charitable community trust that provides rest home level of care for up to 22 residents. There were 16 rest home residents at the time of audit plus one respite care resident and one boarder. The Cottage has funding contracts with the district health board (DHB) to provide aged related residential care (rest home), residential respite - rehabilitation support services, and long term support for chronic health conditions. The facility is a member of an aged care association, and receives regular updates regarding aged care issues. The last resident satisfaction survey results records overall satisfaction with services and care.

		<p>The 2017-2019 strategic plan includes the philosophy and mission statement. The strategic plan includes strength, weakness opportunities and threats analysis and eighteen quality and development goals. From the analysis, there are corrective plans that record the objectives, task, measurable outcomes and expected achievements to address any identified shortfalls. Review of monthly reports to the trust board from the facility manager indicates that progress towards achieving the goals is monitored.</p> <p>There are staff with appropriate skills in the roles of facility management, clinical management and nursing. The management roles, accountability and responsibilities for each role were clearly described in the job descriptions and contracts sampled.</p> <p>The facility manager is a registered nurse with a current practising certificate, has managed the service since January 2017, and has previously worked at the service for over eight years in administration, caregiving, activities and health and safety roles. The facility manager is supported by a full time clinical manager who is a registered nurse (RN) with a current practicing certificate. The position has been vacant since January and a senior registered nurse with relevant skills is acting in the role until an appointment is made. The management team work together to ensure all residents' needs are met by the services provided. All members of the management team have attended over eight hours' education and professional development related to aged care management.</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>	FA	<p>Clinical policies have been reviewed and updated utilising external expertise from consultants and DHB nurse specialists.</p> <p>The service has a quality and risk management plan last reviewed August 2018. There is a document control system that ensures currency is maintained. The service continues to make improvements to the overarching quality and risk management plan including the implementation of internal audits and checklists to monitor the key components of service delivery. Internal audits are scheduled and are conducted on key performance indicators. Staff meeting minutes sighted identify that all quality and risk data is shared and discussed. A summary of quality data is included in the monthly report to the board. The corrective actions from the certification audit (1.2.3.3 &amp; 1.2.3.7) have now been completed.</p> <p>The results of the internal audits and other quality data such as incidents/accidents and infections are collected, reviewed and analysed. The corrective actions that are documented show outcome results following management review. Staff confirmed they are informed of all required corrective actions at staff meetings or at shift</p>

		<p>handover.</p> <p>Quality improvements are undertaken to meet the requirements of the standard and quality improvement records were sighted for medication management, wound assessment and falls management.</p> <p>Actual and potential risks are identified in the hazard register and strategic plan. The hazard risk assessment, risk assessment matrix and hazards register record the likelihood, consequence and rating score. Actions are implemented to eliminate or minimise the risk of occurrence. Staff confirmed that they understood and implemented documented hazard identification processes. Newly found hazards are discussed, monitored and managed by the manager/maintenance person with staff input.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>A documented adverse event reporting policy outlines all reporting requirements including Section 31 of the Health and Disability Services (Safety) Act 2001. This needs to be expanded to include absconding by a resident. The manager confirmed their awareness of the organisation's requirement related to statutory and or/regulatory reporting obligations but was unaware that this included absconding by a resident. There have been two Section 31 notifications to the Ministry of Health since the last audit relating to a pressure area and a change in governance.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information along with any corrective actions is documented. Information is shared at staff meetings, as confirmed in minutes sighted. Documentation in residents' files and the 2018 incident and accident forms reviewed identified that all issues reported had corrective actions put in place when required. The incident and accident forms are viewed and signed off by the facility manager.</p> <p>The principles of open disclosure are evident with clearly documented family/whānau notification of any adverse event or concerns staff may have about a relative's health status. This was confirmed during family/whānau interviews.</p> <p>Management reported during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated and examples were given. Incident and accident numbers are trended and if there is an increase identified appropriate actions are taken.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are</p>	FA	<p>All positions have a documented position description that describes staff responsibilities and accountabilities. Staff complete an orientation programme with specific competencies for their roles. Staff confirmed during interview that the</p>

conducted in accordance with good employment practice and meet the requirements of legislation.		<p>orientation/induction process is overseen by a senior member of staff and that they felt confident to undertake their roles upon completion.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. There was evidence that all required registrations are current. Employment processes included reference checking and annual staff appraisals. The facility manager (registered nurse) has current interRAI training.</p> <p>The education calendar sighted for 2018 and 2019 identifies that staff are offered and undertake training and educational topics relate to aged care and health care services. The plan covers contractual requirements. Education sessions are presented at the facility and staff are informed of upcoming off-site education sessions. Attendance for all education is documented in staff files.</p> <p>Caregivers are encouraged to undertake a recognised aged care qualification. RNs have undertaken the required hours of education to meet Nursing Council requirements. Members of the management team also attend workshops and seminars specific to management related topics.</p> <p>Resident and families/whānau members identified that staff act professionally.</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>	FA	<p>Documented policy that identifies staffing levels and skill mix is maintained to meet residents' needs and to comply with contractual requirements. Documentation identified that adequate numbers of suitably qualified and experienced management, clinical and care staff are rostered on duty. The service also has kitchen, activity, cleaning, administration and maintenance staff. All staff assist with laundry as part of their everyday duties.</p> <p>Rosters sighted showed that staff were replaced for sickness and annual leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents' needs. There is at least one RN on duty for the morning shift Monday to Friday and on call at other times. There is at least one staff member on each shift who holds a first aid qualification. Additional staff are rostered to reflect the occupancy and workload.</p> <p>Resident and family/whānau members stated their needs have been met in a timely manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely</p>	PA Moderate	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p>

<p>manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>A safe system for medicine management using a manual system was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by an RN against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room had not been recorded for the past three weeks.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart.</p> <p>There were two residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner, however these have not been complied with. This remains an ongoing corrective action from the previous audit.</p> <p>Medication errors are reported to the FM and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>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>	<p>PA Low</p>	<p>The food service is provided on site by a cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in June 2017. Recommendations made at that time have been implemented.</p> <p>A food control plan is in place and was registered with the South Taranaki District</p>

		<p>Council 4-April-2018</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The chest freezers however require defrosting, and there is no evidence on the cleaning/maintenance schedule when this was last attended to. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook has been in the role for four months and is being assisted to gain familiarity with the role, by the previous cook. The previous cook and kitchen assistants have relevant food handling training; however, the new cook has no training in food safety</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, and resident meeting minutes. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed.</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>	FA	<p>Except for the documentation referred to in criterion 1.3.3.3, additional documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Residents and family members interviewed expressed a high level of satisfaction with the care provided. Care staff confirmed that care was provided as outlined in discussion and overseen by the facility manager (FM), and confirmed this was not often updated in the care plan. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs. The GP was unable to be contacted on the day of audit, despite several attempts by phone.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for</p>	PA Low	<p>The activities programme is provided by an activity's coordinator, four hours a day, five days a week.</p>

<p>a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>A social assessment and history are not consistently undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are not regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's involvement in activities is recorded weekly and evaluated regularly and as part of the formal six-monthly care plan review.</p> <p>A planned monthly activities programme is sighted. Activities reflect residents', ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include visiting other rest homes, visits from schools, visiting entertainers, nationality days, quiz sessions, house, gardening, baking and daily news updates. The activities programme is discussed at the minuted residents' meetings, run by the resident's advocate. Meeting minutes indicated residents' input is sought and responded to. Residents interviewed who participate in the program, confirmed they find the programme meets their needs.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the FM.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the care provided. Short term care plans were consistently reviewed for infections, pain, weight loss and progress evaluated as clinically indicated. Wound management plans were evaluated each time the dressing was changed, and specialist input sought if required. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness displayed.</p> <p>Staff interview and records reviewed verified that maintenance occurs both as planned annual maintenance and day to day reactive maintenance. This includes the monitoring of hot water temperatures in resident areas. Specialised areas, such as plumbing and electrical work, is undertaken by external contractors and minor repairs are undertaken by the maintenance worker. Electrical safety testing and testing and calibration of clinical by an approved provider has been done within the last 12</p>

		months.
<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>	PA Moderate	<p>There have been no changes to the building or level of services since the last audit. There is an evacuation scheme, however evidence to verify it had been approved by the Fire Service was not available. Six monthly fire evacuations had been undertaken but review of staff training records indicated that 5 staff had not attended in the last 12 months.</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>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures around restraint and enablers meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management at The Cottage and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>The facility is committed to being restraint free and on the day of audit, there were no residents using restraint. One resident was using an enabler, which was the least restrictive and in place voluntarily at the resident's request. This was verified in an interview with the resident. A similar process is followed for the use of enablers as is used for restraints. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.</p> <p>Interviews verify restraint is used as a last resort when all alternatives have been explored.</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>One resident was noted as having absconded from the premises since the last audit. A behaviour management plan was devised and an electronic tracker obtained. No further incidents had occurred There was no evidence that a Section 31 notice had been submitted. On interview the manager was unaware that this was required in this case. The documented policy did not include this requirement.</p>	<p>A Section 31 notice had not been made when a resident absconded from the premises.</p>	<p>Include absconding by a resident in the essential notifications list. Refresh management training regarding events requiring essential notification.</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,</p>	PA Low	<p>Interviews with care staff verified that the temperature of the medication fridge had been above 8 degrees so the medicines that required refrigeration had been moved to another fridge while the original fridge was being repaired. There is no evidence for the past three weeks to verify the temperature of the current medication fridge has been in the</p>	<p>The temperature of the medicine fridge has not been recorded for the past three weeks.</p>	<p>Provide evidence the medicine fridge is operating within the required range to store medicines requiring refrigeration</p>

protocols, and guidelines.		required range for safe storage of refrigerated medicines.		30 days
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Moderate	Two residents at The Cottage, self-administer their inhalers. One resident has an assessment that deems the resident competent to do so by the GP. However, the facilities required three monthly review of competency has not been undertaken for this resident since March 2018. The second resident has no documentation to verify competence. Interviews with both residents verify their full understanding around the facilities requirements of residents who wish to self-administer.	The facility is not able to verify they facilitate residents to safely self-administering medicines.	<p>Provide evidence a system operates to ensure residents who choose to do so, are facilitated to self-administer their medicines in a safe manner.</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 Low	<p>There are no records to verify the cook has training in safe food handling and interview with the cook verifies little knowledge about temperature hazard zones for food. The cook is being assisted by the previous cook, who has food safety training, however there is very little understanding of the requirements or knowledge around the food control plan that has been registered with the council.</p> <p>There is visible build-up of ice in both chest freezers and there is no documentation regarding records of when they were defrosted. There is no evidence the freezers are on the schedule to be regularly defrosted. This is verified by interview with the cook and facility manager.</p>	The new cook has no training in safe food handling. The chest freezers have a build-up of ice and no record of when they were defrosted.	<p>Provide evidence the cook has training in food safety. Provide evidence the freezers are defrosted regularly.</p> <p>60 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in</p>	PA Moderate	Five of six files reviewed did not describe fully the required care the resident required to meet their needs. A resident exhibiting challenging behaviour	Five of six files reviewed did not reflect the required care the resident needed to meet their needs and	Provide evidence care plans reflect residents needs and enable continuity of care to be

service delivery and promotes a team approach where appropriate.		<p>and a potential to wander, had no reference to a tracker being worn, a previous absconding event, the strategies in place to minimise the risk and management of any future episodes.</p> <p>Documentation was not included in the files to record the required strategies around resident's diabetic management, wound management and congestive heart failure management plans.</p> <p>A resident recently re-admitted following acute intervention for a fractured femur, had no updates made to the care plan to reflect changing needs.</p> <p>Interviews with care staff and facility manager confirmed that documentation was not consistently in line with the care the resident required.</p>	enable a coordinated approach and continuity of care.	<p>provided,</p> <p>30 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	Five of six files reviewed had no evidence of an assessment that identified residents' social interests, skills, or resources that would require consideration when developing an activities program that was meaningful to the resident. The activities coordinator verified during interview that activities were in line with residents interests from discussion with the resident, however she confirmed this had not been documented in resident files.	There is no documentation to verify residents' skills and interests are a consideration when planning the activities program.	<p>Provide evidence activities are planned and provided to develop skills and interests that are meaningful to the resident.</p> <p>90 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall</p>	PA Moderate	Six monthly fire evacuations had been undertaken but review of staff training records indicated that 5 staff had not attended in the last 12 months.	Not all staff have attended a fire training and trial evacuation in the last 12 months.	Ensure that all staff attend a fire training and trial evacuation every 12 months.

include fire safety and emergency procedures.				30 days
<p>Criterion 1.4.7.3</p> <p>Where required by legislation there is an approved evacuation plan.</p>	<p>PA</p> <p>Moderate</p>	<p>There have been no changes to the building or level of services since the last audit. However while there is an evacuation scheme, evidence to verify it had been approved by the Fire Service was not available.</p>	<p>There is no evidence that the evacuation scheme has been approved by the Fire service.</p>	<p>Submit the evacuation scheme to the Fire Service for approval.</p> <p>30 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.