Inglewood Welfare Society Incorporated - Marinoto Rest Home

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Inglewood Welfare Society Incorporated
Premises audited:	Marinoto Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 October 2019 End date: 25 October 2019

Proposed changes to current services (if any): The service is also certified for Hospital – geriatric and medical as per MOH letter date 2 October 2019.

Total beds occupied across all premises included in the audit on the first day of the audit: 25

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
	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

Marinoto rest home is a charitable trust governed by governed by Inglewood Welfare Society trust board. Marinoto has been certified to provide rest home and hospital level of care for up to 32 residents however hospital level of services has not yet commenced. On the day of the audit there were 24 rest home residents.

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 and staff.

The rest home is managed by an experienced clinical manager who is supported by a business manager and long-serving staff. Trust board members and the community are actively involved in supporting the service.

The three previous findings remain from the partial provisional around the standing hoist, fire evacuation scheme approval and 24-hour registered nurse cover.

The service has addressed the previous shortfall from their certification audit around quality data. This surveillance audit identified improvements required around corrective action, interventions and medication reconciliation.

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.

Discussions with families identified that they are fully informed of changes in their family member's health status. Information about the Code and advocacy services is easily accessible to residents and families. Complaints policies and procedures meet requirements and residents and families are aware of the complaints process.

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.

Marinoto Rest Home has a documented quality and risk management system. Quality data related to incident and accidents, infection control, restraint and complaints are collected and communicated to staff. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

The registered nurse is responsible for each stage of service provision. The assessments and care plans are developed in consultation with the resident and their whānau/support person. Care plans are evaluated six monthly. The GP reviews the resident at least three monthly.

An activity coordinator is employed five days a week. The activities offered are a reflection of the resident's group and individual recreational preferences. Community links are maintained.

Medication education and competencies are completed annually for the registered nurses and healthcare assistants responsible for administration of medicines. Medication policies reflect legislative requirements and guidelines.

All meals are prepared on-site. Resident's individual food preferences, dislikes and dietary requirements are met. There is a dietitian review of the four-weekly menu. The cooks are trained in food safety and hygiene.

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 low risk.

Marinoto Rest Home has a current building warrant of fitness. There is a reactive and planned maintenance plan in place.

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.

Marinoto Rest Home has restraint minimisation and safe practice policies and procedures in place. On the day of audit, there was one resident using a restraint and one resident using an enabler. Staff receive training around restraint minimisation.

Infection prevention and control

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

The infection control coordinator collates infection events that are analysed for trends and corrective actions. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. There have been no outbreaks.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	5	1	0	0
Criteria	0	40	0	5	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	There is a complaints policy to guide practice, which aligns with Right 10 of the Code. The clinical manager is the privacy officer and leads the investigation of any concerns/complaints. Compliments/concerns and complaint forms are visible at the front entrance. A complaints procedure is provided to residents within the information pack at entry. A complaints register is maintained. There have been five complaints made in 2018 and six complaints (two verbal and four written) received in 2019 year-to-date.t. The documentation for each complaint shows investigation and actions taken for resolution to the satisfaction of the complainant. Complaints and outcomes/corrective actions are discussed (as appropriate) at staff meetings.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	There is a policy to guide staff on the process around open disclosure. Residents (five rest home) and five relatives interviewed confirmed that the staff and management are approachable and available. Sixteen accident/incident forms reviewed identified family were notified following a resident incident. Relatives interviewed confirmed they are notified of any accident/incidents and changes to their relative's health. Families are invited to attend the monthly resident/relative meetings. Member of the Inglewood Welfare Society attends the meetings and residents/relatives ae encouraged to provide feedback and suggestions on the service. Interpreter services are available as required.

conducive to effective communication.		Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Marinoto Rest Home is owned by the Inglewood Welfare Society Incorporated trust. Two board members (interviewed) confirmed all members have been actively involved in the recent building project and continue to support the managers and all staff as the service prepares for the provision of hospital level of care. The service is managed by an experienced clinical manager/registered nurse (RN) with a current practising certificate who oversees all clinical services and quality management for clinical areas. The business manager is non-clinical and has many years' experience working in aged care and is responsible for non-clinical services. Marinoto Rest Home has been assessed to provide hospital level services but currently is providing rest home level of care for up to 32 residents (link 1.2.8.1). There are 26 dual purpose beds (including one double room) and six rest home beds. On the day of audit there were 25 rest home residents including one hospital level resident who has a dispensation and one resident under ACC fund rest home respite care. There is a current business plan April 2019- March 2020 has quality goals that focus on commencing the provision of hospital level care. Progress toward goals is documented in an ongoing manner. The managers provide a monthly report on their respective areas to the Society keeping them up to date with progress. The clinical manager has maintained at least eight hours annually of professional development activities related to managing a rest home/hospital including attending the NZNO gerontology conference (November 2018, on-line privacy module (April 2018), delirium study day at the DHB and attending ARC manager forums. The business manager has completed chemical awareness and a health and safety course this year.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement	PA Low	Marinoto Rest Home has a documented quality and risk management system. The clinical managers' monthly report to the board of trustees covers staffing, resident occupancy, quality improvement activities, accident/incident data, audits (internal and external) and any concerns/complaints/compliments. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service has in place a range of policies and procedures to support service delivery that are developed by an external consultant and reviewed regularly. Staff interviewed confirmed they are made aware of new/reviewed policies. Quality data trends analysis related to incident and accidents, infection control, restraint, medications, wounds and complaints are collected and entered into an electronic data base which analyses and trends events for time of day, day of week with monthly and annual comparisons for the service against industry standards. Monthly staff meeting minutes documented discussion around quality data, trends analysis and any corrective actions required. The previous finding around discussion of quality data has been addressed. There is an annual

principles.		internal audit calendar in place and audits have been completed as per the required schedule, however the corrective actions have not been signed off when completed. Management meetings with the clinical manager, business manager and RN on duty are held monthly. There are daily meetings with the RN and weekly meetings with the activity coordinator and food services staff. Registered nurse meetings are planned to commence when all the RNs have been appointed. Resident/relative surveys are completed annually. The 2018 response while low demonstrated residents/relatives strongly agree/agreed with the level of service provision. There is a health and safety and risk management system in place including policies to guide practice. There are two health and safety representatives who complete regular walk-a-rounds (one interviewed) and review the maintenance and hazard register. Health and safety is discussed at the staff meetings. Staff receive health and safety orientation on employment and ongoing. There is a contractor sign in/out register. The hazard register has been reviewed September 2019 following the completion of the building project. Fall prevention strategies are in place that include the analysis of falls accident/incidents and the identification of interventions on a case-by-case basis to minimise future falls.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an accident/incident reporting policy that includes definitions and outlines responsibilities. Sixteen accident/incident forms (falls, unwitnessed falls, skin tears, medication and behaviour of concern) for the month of September 2019 were reviewed. All document timely RN review and follow-up, however neurological observations had not been completed for all unwitnessed falls (link 1.3.6.1). Discussions with the clinical manager and business manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no essential notifications to report.
Standard 1.2.7: Human Resource Management	FA	There are human resources policies to support recruitment practices. Five staff files (two RNs, two HCAs and one activities coordinator) were reviewed. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Job descriptions were

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		sighted in all files. Annual performance appraisals were up to date. Current practising certificates were sighted for the RNs and allied health professionals involved in the service. The service has an orientation programme in place to provide new staff with relevant information for safe work practice. There is an education planner in place that covers compulsory education requirements over a two-year period. External speakers provide education such as infection clinical nurse specialist, hospice, repertory nurse specialist, social worker, Tui Ora (Maori health provider) and field officers. Staff have the opportunity to attend external education. The RNs are linked to the DHB professional development recognition programme. The RNs and HCAs complete competencies relevant to their role such as medications. Two of five RNs and the clinical manager have completed interRAI training. The activity coordinator is a careerforce assessor.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low	Staff rostering, and skill mix policy is in place. The clinical manager and business manager are full-time from Monday to Friday. The clinical manager is available on-call after hours. The service currently has five RNs (three fulltime and two part-time). The service has enough RNs to provide 24-hour cover to meet the requirement for hospital level of care. The 24-hour RN roster is not yet covered to provide hospital level services. Employment for HCAs will occur as hospital level residents are admitted. There are currently three HCAs on morning duty (two full shift and one five-hour shift). There is a breakfast person (activity coordinator) from 7 am to 9 am to assist residents with breakfast. There is the ability to extend the short shifts to meet resident acuity. There are three HCAs on afternoon shift (two full shifts and one finishing at 8 pm) and two HCAs on night shift. The activity coordinator is on duty from 9 am to 3.30 pm Monday to Friday. There is a dedicated cleaner on duty 7 days/week. There is a volunteer laundry person 2 days/week, otherwise care staff take care of laundry needs. There is a qualified cook on duty seven days supported by morning and afternoon kitchenhand staff.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative	PA Moderate	There are policies and procedures in place for safe medicine management that meet legislative requirements. The supplying pharmacy delivers the regular and 'as required' medication in blister packs. A record of deliveries is maintained; however, there is no documented evidence of medication reconciliation against the medication chart. Senior healthcare assistants and RNs who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided annually. Medications were stored safely in the medication room. The medication fridge has daily temperature checks recorded. The medication room air temperatures are taken and recorded daily. All eyedrops were dated. All medications were

requirements and safe practice guidelines.		within the expiry date. A procedure is in place for the self-administration of medicines. On the day of audit there was one resident self-medicating with a self-medication competency completed. Self-administration monitoring is completed. Ten paper-based medications charts (pharmacy generated) were reviewed. All medication charts met prescribing requirements including indications for as required medications. Allergies and photographic identification were on the medication charts. Administration of medications corresponded with the medication charts. The GP had reviewed the medication charts at least three monthly.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Food service policies and procedures met the requirements of the food control plan. The food control plan has been verified. The service provides a meals-on-wheels service to the community. Food services staff complete food safety orientation on employment and ongoing as part of the education programme. There is a qualified Monday to Friday cook and a weekend cook. They are supported by morning and afternoon kitchenhands. The summer and winter menu have been reviewed by a dietitian and includes normal and soft/pureed meals. The cook receives a dietary profile for each resident and is notified of any dietary changes. Residents dislikes are accommodated. Pureed meals and vegetarian meals are accommodated. The kitchen is closely located to the main dining room and there is a smaller dining room with kitchenette where there is an alternative dining option for residents who may require assistance with meals. Meals are cooked and placed in a bain marie which is transported to the dining room for the serving of meals. Resident to have meals in their rooms. The Tawa dining room has is a kitchenette with tea/coffee making facilities and fridge for fluids and provides an alternative dining area for residents who may require assistance/feeding. A daily food control plan of chiller, freezer and end cooked meat temperatures is completed as sighted. Food stored in the fridge and chillers is covered and dated. Dry goods are stored in sealed containers labelled with the re-filled and expiry dates. A cleaning schedule is maintained. Residents can feedback on the food services at the residents meeting. Residents/relatives interviewed generally spoke positively about the food provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their	PA Low	Residents and relatives interviewed, reported that residents' individual needs were appropriately met, and they were kept informed of any changes to resident's health status and GP visits. Family/whānau/resident representative contact sheets were sighted in resident files and are maintained by the RN. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. When a resident's condition alters, the RN initiates a GP or nurse specialist review. Healthcare assistants reported that they are informed of any changes in health status at handover. Short-term care plans are used to document short-term needs, however not all short-term needs were

assessed needs and desired outcomes.		documented. Adequate dressing supplies were sighted. Wound management policies and procedures are in place. There is access by referral to the district nursing service. Wound assessments and evaluations were in place for three residents with wounds. There were no pressure injuries. Continence products are available and resident files included a continence assessment where appropriate. Observation charts and monitoring records are utilized for a restraint, pain, blood sugars, behaviour, food/fluid intake, weight and bowel monitoring. Neurological observations had not been completed for all unwitnessed falls.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	The activities coordinator has been in the role at Marinoto for three years and is progressing through the diversional therapy qualifications. The activities coordinator works from 9.00 am to 3.30 pm Monday to Friday. The activities programme is planned to reflect resident preferences and suggestions from the monthly resident meetings. Residents receive copies of the activity programme. Activities include (but not limited to); exercises, cards, board games, reminiscing, crafts, music and bowls. A family member is involved in the bowls activity with the residents. A volunteer visits fortnightly to spend one on one time with residents. Community visitors include K9 friends, entertainers, inter-home bowls competitions and church services. An Ironside van is hired for regular outings into the community such as shopping, cafes, senior citizens and other community functions such as mid-winter. Festive occasions and birthdays are celebrated. A resident social profile and cultural assessment is completed following admission and an individual activity plan developed. Activity plans are reviewed six monthly as part of the six-monthly MDT review. Residents and relatives interviewed were positive about the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Evaluation of care plans against resident goals is conducted by the RN with input from the GP, resident, family, healthcare assistants and activities coordinator. Families are notified of any changes in the resident's ability to meet their desired goals. Residents/relatives interviewed confirmed their participation in care plan evaluations. The long-term care plans are reviewed at least six monthly. There is at least a three-monthly review by the GP. Short-term care plans are used for short-term changes in health status and had been reviewed, resolved or if an ongoing problem transferred to the long-term care plan (link 1.3.6.1).
Standard 1.4.2: Facility Specifications	PA Low	The building has a current building warrant of fitness that expires 8 April 2020. The responsibility for maintenance is overseen by the business manager who reports to the IWS committee. Staff record requests for repairs in a maintenance request book that is checked daily and actioned. There is a planned maintenance draft schedule in

Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		place that includes electrical testing, calibrations of clinical equipment and hot water testing. Hot water testing has occurred a-s per schedule and this is an improvement on the previous audit. A computer-based programme with reminders is being developed. The standing hoist has a new sling ordered and requires a new battery before it is fully functional. This previous shortfall continues to require addressing. Essential contractors are available 24 hours. There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the outdoor areas where seating and shade is provided. The healthcare assistants interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the residents' care plans.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	The service has completed remedial work required and awaiting the sign off by the fire service for an approved fire evacuation scheme. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Staff attend six monthly fire drills in the rest home. There are sufficient civil defence and pandemic/outbreak supplies available in the facility for up to 32 residents. There is sufficient food for up to three days, held in the kitchen and second pantry and alternate gas cooking (BBQ and gas hobs in the kitchen). A power supply protection system has been installed to ensure there is uninterrupted power supply until the on-site generator is running. There is a 3,000-litre water tank installed under the new build. Bottled water is also available. There is at least one person on duty at all times with a current first aid certificate. There are call bells in the residents' rooms, ensuites and communal areas in the new build. Entry to the new wing is through the main entrance to the facility. There is a call bell access afterhours. There is external lighting around the new wing and cameras in the corridors and lounge that can be viewed in the administration office.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Data is entered into an electronic system that benchmarks infection events against industry standards. Infection control data including trends and analyses is discussed at the monthly staff meeting. Preventative measures are put in place where trends have been identified. The GP monitors the use of antibiotics. There have been no outbreaks.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The clinical manager is the restraint coordinator. On the day of audit, the service had one resident using a restraint (comfort chair), and there was one resident using an enabler (bedrail). Voluntary consent was sighted for the use of an enabler. Staff receive training around restraint minimisation, and challenging behaviours.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Quality data relating to incident and accidents, infection control, restraint, internal audits and complaints are discussed at staff meetings and meeting minutes included discussion around quality data trends analysis and corrective actions required by staff. Internal audits have been completed as per the annual schedule however not all corrective actions have been followed up and signed off when completed.	Internal audits reviewed that identified shortfalls did not have corrective actions in place, follow-up or sign off when completed.	Ensure corrective actions from internal audits are implemented and signed off when completed. 90 days
Criterion 1.2.8.1 There is a clearly	PA Low	The service currently has five RNs (three fulltime and two part-time). The service	The 24-hour RN roster is not yet covered to provide hospital level services.	Ensure the is 24/7 cover of

documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.		has enough RNs to provide 24-hour cover to meet the requirement for hospital level of care. The 24-hour RN roster is not yet covered to provide hospital level services. Employment for HCAs will occur as hospital level residents are admitted.		RNs rostered prior to the admission of hospital residents. Prior to occupancy days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	All medications are stored safely. The supplying pharmacy provide all medications prescribed. A record of medication deliveries is maintained (sighted); however, there was no record of medication reconciliation of the medications on delivery against the medication chart.	There was no documented evidence of medication reconciliation of the monthly blister packs against the medication charts.	Ensure there is a record of medication reconciliation of medication blisters packs on delivery against the medication charts. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Long-term care plans included supports required to meet the resident needs; however, there were no documented interventions to meet residents' short-term needs or guide care staff to safely deliver care where there were changes to the resident's health status. Monitoring forms were in use where identified to monitor a resident's progress towards meeting desired goals. Neurological observations had not always been completed following unwitnessed falls.	(i). Three of five unwitnessed falls did not have neurological observations completed as per protocol, (ii))there were no documented interventions for one resident with unintentional weight loss; (iii) There were no documented interventions/guidelines for the management of cellulitis for one resident; and (iv) The resident under ACC and at high risk of falls did not have the risks of warfarin identified in the clinical risk plan. There was no evidence of checks for colour, warmth, movement and sensation post change of plaster for a fracture.	(i). Ensure neurological observations are completed as per protocol and (ii)-(iii). ensure there are documented interventions to meet the resident's

				short-term needs. 90 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	There is a full sling hoist that has been checked for function and available for use. There is a standing hoist that has a physical check and requires a new sling which has been ordered. A new battery is required before the standing hoist is safe to use. This continues to be an area requiring improvement.	There is a standing hoist that has a physical check and requires a new sling which has been ordered, therefore it is still not fully functional	Ensure the standing hoist if fully functional prior to use. Prior to occupancy days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	The risk is considered low as an application has been re-submitted to the fire service for approval and the service is awaiting the outcome. All staff have completed six monthly fire drills.	The service has carried out remedial work required to meet fire service approval including installation of a fire wall in the kitchen. An application for fire service approval has been re-submitted.	Ensure there is a fire service approved evacuation scheme. Prior to occupancy days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.