

Chetty's Investment Limited - Glenbrook 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 BSI Group New Zealand Ltd, 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: Chetty's Investment Limited

Premises audited: Glenbrook Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 5 November 2020 End date: 6 November 2020

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 22

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Glenbrook Rest Home provides rest home level care for up to 23 residents. On the day of the audit, there were 22 residents living at the facility.

This unannounced surveillance audit was conducted against a subset of the Health and Disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, relatives, staff, the general practitioner, and the owner/manager.

The registered nurse is recently appointed and is supported by a registered nurse who provides oversight of two facilities owned by the same owner/manager. Residents and relatives interviewed were very complimentary of the services and care they receive.

The service has addressed one of the three shortfalls identified at the previous certification audit around service agreements. Shortfalls continue to be required around adverse event documentation and medications.

This surveillance audit identified areas for improvement around the quality improvement programme; timeframes to complete assessments and care plans; documentation of interventions and updating of the care plan as changes to interventions occur; and monitoring of food temperatures when food products are delivered.

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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service.

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 medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. An owner/manager and registered nurse are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is documented, and data collected. Corrective action plans are documented when opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training includes in-service education and competency assessments.

Registered nursing cover is provided at least 40 hours a week with registered nurse cover at all times. Residents and families report that staffing levels are adequate to meet the needs of the residents.

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 nurse is responsible for each stage of service provision with this including assessment and development of the care plan. Care plans reviewed in resident records demonstrated service integration. Resident files included the general practitioner, and allied health notes.

Medications are administered using an electronic management system. The registered nurse and staff complete an annual competency assessment and receive annual education. There is evidence of the three-monthly medication reviews being completed by the general practitioner.

All meals and baking are done on-site. Residents' food preferences, dietary and cultural requirements are identified at admission and in an ongoing manner and accommodated. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

One activity coordinator oversees the activity programme for the residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural, and cognitive abilities and preferences.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building holds a current warrant of fitness. There is a preventative and planned maintenance schedule in place. Equipment is tested, tagged, and calibrated.

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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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. No restraint was used during the audit and four enablers were in use (Adams poles).

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated, and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	11	0	3	3	0	0
Criteria	0	36	0	3	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints process is provided to residents and families during the resident's entry to the service. Access to complaints forms are available in a visible location. A complaints register is in place. One complaint has been lodged on the complaints register since the last audit. A review of the complaint confirmed that an investigation had taken place in a timely manner with confirmation that the complainant was satisfied with the outcome. An open-door policy is in place.</p> <p>Discussions with five residents and three families confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p> <p>There have not been any complaints from external authorities since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff interviewed understood about open disclosure and providing appropriate information when required.</p> <p>Three family members interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Eleven accident/incident forms reviewed reflected documented evidence of families being informed following an adverse event when the event warranted this as per discussion</p>

communication.		<p>with the family.</p> <p>An interpreter service is available and accessible if required through the district health board. Families and staff are utilised in the first instance. There were no residents at the facility who were unable to speak or understand English.</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>Glenbrook Rest Home provides rest home level care for up to 23 residents. On the day of the audit, there were 22 residents at the facility including two using respite care. All residents were on the Aged Related Residential Care (ARRC) agreement. A philosophy, mission, vision, and values are in place. The strategic and business plan (2020) is regularly reviewed by the owner/manager of the rest home. Goals are signed off when implemented.</p> <p>The owner/manager has been managing this facility for two years and also manages a rest home in Otahuhu, Auckland. The owner/manager reported that they are on-site at Glenbrook Rest Home seven days a week. The owner/manager is supported by a registered nurse (RN) who provides support for both registered nurses at the two rest homes. The registered nurse providing oversight has 20 years' experience in aged care.</p> <p>The registered nurse has been in the role since June 2020. This is the registered nurses first placement in aged care services however they have a background overseas in intensive and critical care for four years</p> <p>The owner/manager has maintained a minimum of eight hours of professional development relating to the management of an aged care facility.</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>	PA Low	<p>A quality and risk management system is understood by the managers and staff and is being implemented as confirmed during interviews with the owner/manager and staff.</p> <p>Policies and procedures align with current good practice. These policies have been developed by an external consultant. They are reviewed regularly as per the document review schedule. New policies and policy amendments are discussed with staff. The consultant supports the RN and the service through on-site visits and facilitation of ongoing training along with review of policies and procedures.</p> <p>Quality management systems are linked to the internal audit programme, incident and accident reporting, infection control data collection, resident/family satisfaction surveys and complaints received (if any). An audit schedule is implemented in a timely manner. Data is collated, analysed, and shared with staff through the staff meeting held monthly. When improvements are identified, corrective actions are documented. Resolution of issues when these arise from completion of audits is not documented.</p> <p>A risk management plan is in place. Health and safety policies have been updated to reflect current legislative requirements. Staff health and safety training begins during their orientation to the service. Health and safety is</p>

		<p>a regular agenda item covered in the staff meetings. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise the risk. Newly identified hazards are documented on a hazard identification form. Contractors are orientated to the facility's health and safety programme. The health and safety representative interviewed was able to describe the role as escalating and managing issues identified by staff.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes decluttering residents' rooms and intentional rounding.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident. Incident/accident data is linked to the service's quality and risk management programme.</p> <p>Eleven accident/incident forms were reviewed. Each event involving a clinical adverse event reflected a clinical assessment and follow up by the RN. Accident/incident forms (implemented in September and October 2020) reflected documented evidence of an RN investigation. The recommendation related to investigation of incidents identified at the certification audit has been addressed. Neurological observations are conducted by the caregivers for unwitnessed falls. however, these are not documented as per policy. This criterion around adverse event follow up remains an area for improvement.</p> <p>The caregivers reported that they contact the RN and are given directions by the RN.</p> <p>The owner/manager is aware of statutory responsibilities in regard to essential notifications. There have not been any section 31 reports that have had to be completed since the last audit. The Ministry of Health and the DHB have been notified of the appointment of a new registered nurse.</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>Human resources policies are in place, including recruitment, selection, orientation, and staff training and development. Five staff files reviewed (two caregivers, one registered nurse, one cook, one activities coordinator/caregiver) included evidence of the recruitment process (e.g., reference checking, signed employment contracts, signed job descriptions, and completed orientation programmes). The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed stated that they believed new staff were adequately orientated to the service. The new registered nurse states that they have had a comprehensive orientation and are fully supported by the experienced registered nurse who is on site five days a week. Documentation reviewed confirmed the orientation programme. Staff are given annual performance appraisals annually.</p> <p>An education and training programme is provided for staff that exceeds eight hours per year. The majority of in-services are conducted by an external consultant. Competencies completed include death and dying; infection</p>

		<p>control; behaviour management; medication; first aid; abuse/neglect; fire evacuation; and personal care/hygiene. Medication competencies are repeated annually. The registered nurse has completed interRAI training.</p> <p>All staff have a current first aid certificate.</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>Staffing aligns with contractual requirements. The owner/manager reports that they are on-site seven days a week and enjoys coming to the facility over the weekends to speak with families and residents. The registered nurse is on-site five days week (minimum of 36 hours per week). They live on site and respond to any on call requests.</p> <p>A second experienced RN currently provides on-site support five days a week for the registered nurse and would be able to cover any registered nurse leave.</p> <p>There are adequate numbers of caregivers available. Two (long-shift) caregivers are rostered on the AM shift, and two caregivers (one long shift and one short shift) are rostered on the PM shift. One caregiver is rostered during the night shift. Caregivers are responsible for laundry and cleaning.</p> <p>One staff is rostered for activities. The activities coordinator works four days a week and provides 16 hours of activities.</p> <p>Staffing is flexible to meet the acuity and needs of the residents. Interviews with residents and families confirmed staffing overall was adequate to meet their needs.</p> <p>There are no bureau staff used and caregivers provide cover when others are on leave.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry into the service is facilitated in a timely and respectful manner. Pre-admission information packs include information on the services provided for resident and families. All residents had a copy of the updated admission agreement with this signed on the day of admission or within three days. Exclusions from the service are included in the admission agreement.</p> <p>The shortfall identified at the certification audit related to each resident having an updated agreement has been addressed. Residents and the family member interviewed stated that they had received the information pack and had received sufficient information prior to and on entry to the service.</p>
Standard 1.3.12:	PA	<p>There are policies available for safe medicine management that meet legislative requirements. All medications are stored appropriately. The service uses an electronic management system for medication. Ten medication</p>

<p>Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>Moderate</p>	<p>charts were reviewed. All medication charts sampled were legible, up to date and reviewed at least three-monthly by the GP. All 'as required' medication charted included an indication for use. All medication signing sheets were signed following administration.</p> <p>The RN and caregivers who administer medications had been assessed for competency and attended education on an annual basis. A caregiver was observed to be safely administering medications on the day of audit. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. There are no standing orders in use. The ambient temperature of the medication room is taken weekly. There are no vaccines stored on site.</p> <p>There are currently two rest home residents who self-administer medication and one resident interviewed confirmed that they inform the nurse manager when taken. Staff interviewed confirm that both residents inform staff when they have taken their medication. Each resident has a competency completed.</p> <p>Currently one bottle of liquid medication is used for any resident prescribed this. The shortfall identified at the certification audit remains. There are also shortfalls identified around a prescription and documentation of allergies for residents in respite care.</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 service employs a cook and a chef who work four days on and four off. They prepare the evening meal and the caregivers heat and serve this. Both have current food safety certificates. There is a small but well-equipped kitchen, and all meals are cooked on-site. Meals are served from the kitchen, which opens into the dining room. Residents eating in their rooms have meals delivered on trays with the food covered and kept warm. On the day of audit, meals were observed to be hot and well presented.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Kitchen refrigerator, food and freezer temperatures were monitored and recorded daily. Temperatures of food, when delivered has not been taken since September 2019.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six-monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets were noted on the kitchen noticeboard, which can be viewed only by kitchen staff. An external dietitian has approved the menus in 2018. The service has been verified against the Food Control Plan as per current legislation. Residents and families interviewed were very happy with the meals provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>PA Moderate</p>	<p>The caregivers follow the care plan and report progress against the plan at least daily or more frequently if needed. If external nursing or allied health advice is required, the RN will initiate a referral. If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g.,</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>dressings). Sufficient continence products are available and resident files include a continence assessment and plan.</p> <p>Three wounds were reviewed (one skin tear and two scratches). Wound assessments and care plans or short-term care plans were not documented for the wounds. The wounds have been reviewed in appropriate timeframes. The RN has access to specialist nursing wound care management advice, and this could be described at interview.</p> <p>Interviews with the two RNs and caregivers demonstrated an understanding of the individualised needs of residents. Monitoring charts are completed as required.</p> <p>Not all interventions were well documented in resident files reviewed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities coordinator is employed to cover four hours a day, for four days a week to coordinate the activities programme for all residents. They are assisted by a caregiver one additional day a week. There are also occasional weekend activities. Each resident has an individual activities assessment undertaken as part of the interRAI assessment (link 1.3.6.1) and from this information, an individual activities plan is developed.</p> <p>Each resident is free to choose whether they wish to participate in the activities programme. Participation is monitored. There is community involvement which includes visits from children, visits to the community and church visits. The facility has its own van for outings with a second van from a sister facility able to be used if needed. Recent activities have included discussion groups, sing-a-longs, bingo, and quizzes. Hand massages and individual activities are also provided.</p> <p>All long-term resident files sampled have a recent activities assessment and plan within the care plan (LTCP) and this is evaluated at least six-monthly when the care plan is evaluated. Residents and the family member interviewed commented positively on the activity programme.</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>Long-term care plans reviewed had been evaluated at least six-monthly or earlier if there is a change in health status in files sampled. Four of the five files reviewed all have an interRAI re- assessment and an in-depth evaluation of care (link 1.3.6.1). One resident did not require evaluation of the care plan at this point.</p> <p>There was at least a three-monthly review by the GP in the files reviewed. Care plan reviews are signed by the RN in files sampled. Short-term care plans reviewed were evaluated and resolved or added to the long-term care plan if the problem was ongoing, in resident files sampled. At times, the care plan is updated as changes to interventions occur (link 1.3.6.1).</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building holds a current warrant of fitness, which expires 31 May 2021.</p> <p>The registered nurse manages the reactive and preventative maintenance. When an issue requiring maintenance is noticed, the owner/manager ensures that it is completed. External contractors are engaged to complete work as required. A sample of hot water temperatures are taken monthly, and these are maintained at (or just below) 45 degrees. Medical equipment is maintained and calibrated annually.</p> <p>The facility's amenities, fixtures, equipment, and furniture are appropriate for the level of service contracted. There is sufficient space to allow residents to move around the facility freely. The hallways are wide enough for appropriate traffic. There is non-slip linoleum in showers and toilet areas throughout the facility. The main hallways and living areas are carpeted. The lounge areas are designed so that space and seating arrangements provide for individual and group activities. Residents' bedrooms throughout the facility have resident's own personal belongings displayed.</p> <p>External areas and garden areas surrounding the facility are well maintained and have decking and shade. There is a designated outdoor smoking area.</p> <p>Staff stated they had sufficient equipment (including personal equipment to support individual needs) to safely deliver the cares as outlined in the resident care plans for all people receiving services.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is outlined in the infection prevention and control programme and described in policy. The surveillance activities are appropriate to the size of the service. The infection control coordinator (registered nurse) oversees the monitoring activities.</p> <p>Surveillance data is documented. Monthly analysis is completed and reported at monthly staff meetings, which are a standing agenda item. The service collected all infections and as well as aggregated data for all residents, each resident has an infection log. Three of the five resident files reviewed had a log completed with all infections logged appropriately and captured in infection control data. These logs are used to assist the six-monthly resident reviews and three-monthly GP reviews. There have been no outbreaks of infection since the previous audit.</p> <p>The service has provided comprehensive information around Covid to family, residents, and staff. There is sufficient PPE to manage any outbreak for at least two weeks. There is a Covid 19 plan in place to manage any risks or changes in practice should there be an outbreak. The two RNs interviewed could describe donning and doffing of PPE and set up of an isolation room if required. There are paper towels in each room including bathrooms and pump soap. There have not been any outbreaks since the last audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraint minimisation. No residents were using restraints and four were using enablers (Adams pole or monkey bar to help them to get out of bed). The registered nurse is the designated restraint coordinator. They are knowledgeable regarding minimising the use of restraints. Staff receive training on restraint minimisation, which begins during their orientation to the service.</p>
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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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	An internal audit schedule is documented. Audits are completed and corrective action plans documented when issues or gaps are identified. The evidence of resolution is not linked to the audit and although the registered nurse who completes the audit is able to show evidence of resolution, this would not be able to be identified on the audit form.	There is no evidence of resolution of issues when corrective action are identified i.e. through audits.	<p>Ensure that there is documentation of resolution of issues as these arise.</p> <p>180 days</p>
<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</p>	PA Moderate	Accident/incident forms (implemented in September and October 2020) reflected documented evidence of an RN investigation. The recommendation related to investigation of incidents identified at the certification audit has been addressed. Neurological observations are conducted by the caregivers for unwitnessed falls. however, these are not documented as per policy. This criterion around adverse event follow-up remains an area for improvement.	Four of four incidents that involved a head injury or that was not witnessed did not have neurological observations taken as per policy. The shortfall identified at the previous audit remains.	Ensure that neurological observations are taken as per policy for a resident who has an unwitnessed fall or who has sustained an injury to their head as a result

risk.				of a fall. 90 days
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>One bottle of any liquid medication is put onto the trolley e.g. lactulose and all residents prescribed this have the medicine administered from the single bottle. This remains a corrective action from the certification audit.</p> <p>Residents using respite care bring in medications with a prescription in one of the three files reviewed and a signing sheet. Allergies are documented in the resident file for two of three respite residents.</p>	<p>(i). Staff do not administer liquid medication from a bottle prescribed to them but use one opened bottle on the medication trolley. The corrective action remains.</p> <p>(ii). Two of three resident medication files (respite) did not include a copy of the prescription.</p> <p>(iii). One respite resident file did not include allergies documented on the medication chart or in the file, and these were not documented in the medication signing sheets or prescription for the other two respite residents.</p>	<p>(i). Administer medication only from a bottle prescribed to that resident.</p> <p>(ii). Ensure that a copy of the prescription is provided for respite residents.</p> <p>(iii). Ensure that allergies are documented in the resident file and the medication folder for respite residents.</p> <p>60 days</p>
<p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>	<p>PA Low</p>	<p>Temperatures of food when delivered is expected to be taken on delivery. The cook gave an example of turning a delivery away when the delivery had been four hours late.</p>	<p>Temperatures of food when delivered has not been taken since September 2019.</p>	<p>Ensure that the temperature of food when delivered is taken and maintains temperatures with normal range as per policy.</p>

				60 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Timeframes for completion of interRAI assessments are documented in the policy. The registered nurse who provides oversight of two facilities including Glenbrook Rest Home stated that they had difficulty completing these during lock down (Covid 19 pandemic) and had also had the resignation of the registered nurse who had previously been completing these.</p> <p>Four long term resident files were reviewed for completion of documentation in a timely manner.</p>	<p>(i). Three of four resident files did not evidence completion of the initial interRAI in a timely manner.</p> <p>(ii). Three of four resident files did not evidence completion of the initial long-term care plan.</p> <p>(iii). One care plan had been reviewed prior to the interRAI being completed.</p> <p>(iv). One care plan had not been reviewed six monthly as required.</p>	<p>(i)-(iv). Ensure that timeframes for completion of initial interRAI and care plans and ongoing documentation of interRAIs and review of care plans is completed in a timely manner as per policy.</p> <p>180 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>Three wounds on the wound register were reviewed (one skin tear and two scratches). Reference to the wounds were documented in the progress notes. A wound assessment and care plans or short-term care plan was not documented for the wounds.</p> <p>Not all interventions were well documented in resident files reviewed. This included a lack of interventions documented in the care plan for a resident who wanders with some aggressive behaviour; interventions for weight loss; and generic interventions for a resident with falls. The care plan did not reference updates for interventions as these occurred.</p>	<p>(i). Wound assessments and care plans are not well documented.</p> <p>(ii). The care plan did not include individualised interventions for specific issues identified.</p> <p>(iii). The care plan was not always updated with interventions as these changed.</p>	<p>(i). Document wound assessments and care plans and refer to these in the long-term care plan.</p> <p>(ii). Document individualised interventions for specific issues identified.</p> <p>(ii). Update the care plan with interventions as</p>

				these change. 60 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.