

Heritage Lifecare (BPA) Limited - Elizabeth R

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 The DAA Group 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:	Heritage Lifecare (BPA) Limited	
Premises audited:	Elizabeth R	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 4 February 2021	End date: 4 February 2021
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:	37	

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

Elizabeth R provides rest home and hospital level care for up to 38 residents. The service is operated by Heritage Lifecare Limited and managed by a care home and village manager and a clinical services manager. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the Taranaki District Health Board. The audit process included review of policies and procedures, review of staff and residents' records, observations and interviews with residents, family members, management, staff, contracted allied health professionals and a nurse practitioner.

There were no corrective actions to follow-up from the previous report. This audit has resulted in two identified areas of improvement relating to service delivery care plans and service provider availability and allocation of staff to cover the size and design of the facility.

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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Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to interpreting services if needed.

A complaints register is maintained with complaints resolved promptly and effectively. Feedback is provided to staff and quality improvements are initiated and implemented as needed.

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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Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review.

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 of Elizabeth R are assessed on admission by the multidisciplinary team. Assessments are within the required timeframes. Shift handovers, communication sheets and an 'electronic message board' guides continuity of care.

Care plans are individualised, and files reviewed demonstrated that generalised needs, goals, and outcomes are reviewed on a regular basis. 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 provided by a recreation officer. The programme provides residents with a variety of individual and group activities and maintains their links with the community. A rental van was being used for outings at the time of audit, whilst the facility van is waiting replacement.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using an electronic system. Medications are administered by registered nurses 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 supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. 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.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There was a current compliance expiry date as per the building systems status report reviewed. Electrical equipment has been tested as required. There have been no changes to the facility 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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Elizabeth R has implemented policies and procedures that support the minimisation of restraint. No enablers and three restraints were in use at the time of the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff interviewed demonstrated a sound knowledge and understanding of the organisation's 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 of aged care specific infections is undertaken, and data is analysed, trended and benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	14	0	0	2	0	0
Criteria	0	38	0	0	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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	<p>The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that 11 complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans show any required follow up and improvements have been made where possible. The care home and village manager (CH&VM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been two Health and Disability Commissioner's (HDC) complaints received since the previous audit which have both been effectively closed out. Quality learnings and outcomes were fed back to staff and this was verified in the minutes of the quality and staff meetings.</p>
Standard 1.1.9: Communication Service providers communicate	FA	<p>Staff interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Staff also knew how to access interpreter services if required through the Taranaki District Health Board or from local sources.</p> <p>Residents and families at interview stated that they were kept informed about any significant changes to their/their</p>

effectively with consumers and provide an environment conducive to effective communication.		relative's health status or wellbeing. In addition to this, they were advised in a timely manner if any incidents or accidents occurred and/or if any urgent medical reviews were needed and the outcomes.
<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>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly reports to the support office showed adequate information to monitor performance is reported including financial performance, emerging risks and staffing and/or any impending issues.</p> <p>The service is managed by the care home & village manager (CH&VM) who is an enrolled nurse and has worked at this facility for twenty years and has been in the management role for six months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The CH&VM confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending TDHB aged care residential care meetings held at TDHB. The CH&VM also completed the manager induction for Taranaki aged care services which covered contact persons available for TDHB gerontology clinical nurse specialist, 'yellow envelope' transfer systems, aged residential care responsibilities, section 31 notifications and other topics. There is also a leadership in aged care forum programme and regular meetings are held in the New Plymouth and/or Stratford region. Minutes of the meetings are maintained, and copies were accessible. The clinical services manager (CSM) has only been in the role for two weeks.</p> <p>The service holds contracts with TDHB for rest home level care, hospital, respite, GP bed and long term chronic health (LTCH). On the day of audit there were twenty-one rest home level care residents, sixteen hospital level, no respite, GP or LTCH level care residents. Nineteen (19) beds are dual purpose beds. Elizabeth R has five independent boarders who reside in an external building close to the 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</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, falls, medication errors, resident behaviours causing concern, near misses, clinical incidents including infections and restraint minimisation and safe practice.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings held monthly. Staff reported their involvement in quality and risk management activities through internal audit activities, and the quarterly facility health check completed by the CH&VM. The annual satisfaction survey of residents, relatives and/or staff is undertaken from the organisation's</p>

system that reflects continuous quality improvement principles.		<p>support office. For this last survey results and actions taken in response were followed-up; however, the organisation will be reviewing the methodology for completing the surveys due to minimal response rate from residents/families.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. This is managed by the quality management team at the support office and any new policies/procedures are signed off by the regional operations manager. The service administrator is responsible for ensuring that any new or revised policies are put out for staff to view and when signed off ensures these are placed into the current system and any obsolete documents are filed and stored appropriately.</p> <p>The CH&VM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The hazard identification and risk monitoring system was reviewed and all risks are categorised. The hazard register was sighted and was up to date.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the regional quality manager monthly by the clinical services manager (CSM).</p> <p>The CH&VM described essential notification reporting requirements, including for pressure injuries. They advised there has been one Section 31 notification of a significant event made to HealthCERT since the previous audit, in relation to a fire service alarm call out caused by a faulty smoke detector. There have been no other external agency notifications.</p>
Standard 1.2.7: Human Resource Management	FA	Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's

Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		<p>policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. A workbook is completed by staff relevant for the role to be undertaken. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. A staff member from another service provider within the organisation is the designated internal assessor for the programme. There are 19 caregivers employed all of whom have completed level 3 (NZQA) and one caregiver has completed level 4 (NZQA). The activities officer has completed diversional therapy level 4. All caregivers have been offered the opportunity to complete level 4 and when they respond they will be enrolled.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</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>	PA Moderate	<p>There is a documented and implemented process for determining staffing and skill mix which is calculated from the organisation's support office. On visual inspection the allocation of staff does not appropriately meet the identified needs and acuity of the residents (refer to 1.3.3.4). In addition to this, the design, size and layout of the two designated care wings does not appear to have been fully considered when providing adequate staff. The 'red' and 'blue' wings both have rest home and hospital level residents for staff to care for each shift. One wing has 17 residents and the other 19 residents. Care staff reported they worked as a team to complete the work allocated to them. Care staff are also responsible for covering the laundry during the day and afternoon shift.</p> <p>An after-hours on-call service is available.</p> <p>Observations and review of a four-week roster cycle confirmed staff cover has been provided, with staff replaced in any unplanned absence.</p> <p>At least one staff member on duty has a current first aid certificate and there is 24 hour a day, seven day a week (24/7) RN coverage in the facility at all times.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	FA	<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>A safe system for medicine management using an electronic system was observed occurring at Elizabeth R on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>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 reviewed were within the recommended range.</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 was consistently recorded on the electronic medicine chart.</p> <p>There was one resident who self-administers an inhaler. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the RN and CSM 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 at Elizabeth R.</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>FA</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 on 15 January 2021. Recommendations made at that time have been implemented.</p> <p>A food control plan audit was undertaken on 19 January 2020, by the Stratford District Council. Three areas requiring corrective actions were identified which were: a planned kitchen maintenance schedule was required, an acceptable defrosting method for food was to be implemented and evidence of confirmation of staff training on the foods control plan. All corrective actions have been addressed and are ready to be submitted to the council by 19 February 2021.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines. Food temperatures, including for high-risk items, are monitored appropriately, and recorded as part of the plan. The cook has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</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 was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. The areas of dissatisfaction around the tea meal by some residents is being addressed. Ten residents were asked following their lunch how the lunch was, nine expressed satisfaction, while one requested more salt. The salt was available for the resident to add as desired. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There were sufficient staff on duty in the dining rooms at mealtimes 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>With the exceptions of that referred to in criterion 1.3.3.4, documentation, observations, and interviews verified the care provided to residents was consistent with their generalised needs, goals, and the plan of care. The attention to meeting a wide range of resident's individualised needs was evident in all areas of service provision. Five of the six family members interviewed were complimentary of the care provided by Elizabeth R (the sixth family member is referenced in criterion 1.3.3). The NP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a good standard. Care staff confirmed that care was provided as outlined in verbal handovers and RN direction. A range of equipment and resources was available at Elizabeth R, this was suited to the types of care provided and in accordance with the residents' needs.</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>	FA	<p>The activities programme is provided by a recreation officer.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities, and social requirements. Activities assessments are regularly reviewed to help formulate an activity programme that is meaningful to the residents. The resident's activity needs are evaluated regularly and as part of the formal care plan review every six months.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included exercise sessions, walks, inter-rest home games, visiting entertainers, quiz sessions and daily news updates.</p> <p>The activities programme is discussed at the quarterly residents' meetings and minutes indicated residents' input is sought and responded to. Residents and family meetings are run by one of the two residents' advocates, with the recreation officer taking the minutes. Concerns noted are dissatisfaction with evening meal and lost laundry. These concerns are being addressed by the CH&VM. Meeting minutes demonstrated satisfaction with the activity programme. Residents interviewed confirmed they find the programme meets their needs. One family member</p>

		made comment that when the recreation officer takes the village residents out, there are no activities provided during the recreation officer's absence. The CH&VM has addressed that concern by employing a person experienced and trained in activities to relieve the recreation officer when this occurs.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</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 plan of care. Short-term care plans are consistently reviewed for infections, pain, and weight loss. Progress is evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Wound management plans were evaluated each time the dressing was changed. 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>	FA	<p>The building systems status report evidences the compliance schedule anniversary as the 4 July 2021. The report is issued in lieu of a building warrant of fitness (Form 12). A building warrant of fitness was unable to be supplied and displayed due to Covid 19 Alert Level restrictions preventing one or more scheduled inspection and/or maintenance procedures of the compliance schedule from being carried out. All specified systems in the building are currently performing to the performance standards stated in the building's compliance schedule.</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</p>	FA	<p>Surveillance of infections at Elizabeth R is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the resident's clinical record. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>The infection control officer (ICO) and the CSM review all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via quality and staff meetings and at staff handovers. Surveillance data is entered in the organisation's electronic infection database. Graphs are produced that identify trends for the current year, and</p>

control programme.		<p>comparisons against previous years. Data is benchmarked internally within the group's other aged care providers.</p> <p>A good supply of personal protective equipment is available. Elizabeth R has processes in place to manage the risks imposed by Covid-19.</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 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 in the facility and demonstrated a good understanding of the organisation's policies and procedures, the role and the responsibilities involved. On the day of audit three residents were using a restraint and no enablers were in use. Enablers are the least restrictive and can be used voluntarily at the request of the resident. A similar process is followed for the use of enablers as is used for restraints.</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 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	<p>PA</p> <p>Moderate</p>	<p>The rosters were reviewed and discussed with the CH&VM. There are two wings, one with 17 residents (12 rest home level care residents and five hospital level care), and one with 19 residents (10 hospital and nine rest home level care residents). Two care staff are allocated to these wings on the day shift with registered nurse oversight and the CSM is available Monday to Friday. On one wing, there is a split shift of a caregiver working 7am to 1pm and returning 4.30pm to 7.30pm (same staff member). On the other wing there is a staff member rostered to cover 3pm to 8pm. Two care staff are rostered on the afternoon shift and on the night duty. RN cover on afternoon and night is available. There is a staff member on duty who has completed first aid training on all shifts. Three family members made comments around staff shortages and staff being run off their feet. Three residents mentioned calls for assistance at times take a long time to be responded to.</p>	<p>The rosters reviewed and allocation of staff does not currently meet the needs of the residents. In addition to this the design, of the two designated wings and the acuity of the hospital level residents in each wing has not been considered adequately when allocating staff to cover and meet the individual needs of the residents.</p>	<p>Ensure the allocation of care staff is increased to appropriately meet the acuity and needs of all residents on all shifts, taking into consideration the design of the service and the additional allocation of responsibilities that the staff have to complete on the relevant shifts.</p>

				90 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>A review of eight files, found five of the eight files had minimal nursing documentation that identified the nursing strategies required to manage the resident's medical conditions and ensure continuity of care in a coordinated manner. This specifically related to residents with congestive heart failure, residents on anticoagulant therapy, a potential bowel obstruction, and non-insulin dependent diabetic. Concerns/actions are documented in progress notes; however, these are not consistently recorded on a short-term care plan or updated in the long-term care plan and a previous concern could be forgotten. This is a documentation issue as evidence was sighted of management strategies being carried out. Interview with the CSM verified the CSM was aware the documentation did not fully describe the care the resident required to ensure continuity of care in a coordinated manner. A plan was to be implemented to educate the RNs accordingly.</p>	<p>There was minimal documentation in care plans to describe the nursing strategies required to manage residents' medical conditions and to ensure continuity of care could be provided.</p>	<p>Provide evidence the care plans fully reflect the residents care needs, to ensure continuity of care can be provided.</p> <p>90 days</p>

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.