

# CHT Healthcare Trust - CHT Glynavon

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## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	CHT Healthcare Trust
<b>Premises audited:</b>	CHT Glynavon
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 September 2017    End date: 15 September 2017
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	31

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

CHT Glynavon is owned and operated by the CHT Healthcare Trust. The service provides cares for up to 32 residents requiring hospital and rest home level care. On the day of the audit, there were 31 residents. The service is overseen by a unit manager, who is a registered nurse and well qualified and experienced for the role and is supported by the area manager. Residents and the GP interviewed spoke positively about the service provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

This surveillance audit has identified the following areas requiring improvements; open disclosure, service provision, care planning, and medication.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Residents and families interviewed report that they are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

## 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.		Standards applicable to this service fully attained.
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There is a documented quality and risk management programme. Quality and risk information is reported at staff meetings. Residents and family are provided with the opportunity to feedback on issues during resident meetings and via annual satisfaction surveys.

Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. An education and training programme is provided. There is an annual performance appraisal process in place.

The service has a documented rationale for determining staffing. Care staff, residents and family members report staffing levels are sufficient to meet residents' needs. The unit coordinator (a registered nurse) covers on-call when not on-site. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses complete admission assessments using the interRAI assessment tool. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate allied health input into the care of the resident. Care plans are reviewed at least six-monthly.

Medication policies reflect legislative medicine requirements and guidelines.

An activities programme is in place. The programme includes outings, entertainment and activities that meet the recreational preferences and abilities of the residents. Residents expressed satisfaction with the activities provided.

All food is prepared on-site. Residents' nutritional needs are identified and documented. Alternative choices are available for dislikes. Meals are well presented. Residents commented positively on the 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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A current building warrant of fitness is posted in a visible location. (15 June 2018)

## 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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There is a restraint policy that includes comprehensive restraint procedures. There are clear guidelines in policy, which include documented definitions of restraints and enablers that align with the definitions in the standard. There are currently three residents using an enabler and five residents using restraint. Staff receive training on restraint minimisation and managing challenging behaviours.

## 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 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	13	0	3	1	0	0
Criteria	0	39	0	3	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of complaints process. A complaints form is available. Information about complaints is provided on admission. Interviews with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaint register. Verbal and written complaints are documented. There have been six complaints in 2016 and nil YTD in 2017. All complaint documentation was reviewed. All six complaints had noted investigations, timeframes, corrective actions when required, and resolutions were in place if required. Results are fed back to complainants. Discussions with residents (two rest home and three hospital) confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>PA Low</p>	<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 policy also describes that open disclosure is part of everyday practice. The staff interviewed (four healthcare assistants, two registered nurses, one cook, one physiotherapist, one activities coordinator, one unit manager and one area manager) understood about open disclosure and providing appropriate information and resource material when required.</p> <p>Families interviewed (two hospital) confirmed they are kept informed of the resident's status, including any events</p>



<p>provide an environment conducive to effective communication.</p>		<p>adversely affecting the resident. Communication with families is documented in the progress notes, and was identified with a stamp in the files reviewed. Eight incident forms were reviewed, however not all incident forms and progress notes entries evidenced families had been informed following the adverse event.</p> <p>An interpreter service is available and accessible if required through the DHB. Families and staff are utilised in the first instance.</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>	<p>FA</p>	<p>CHT Glynavon is owned and operated by the CHT Healthcare Trust. The service provides rest home and hospital level care for up to 32 residents. The service advised that one double room has been permanently converted to a single room since the previous audit. On the day of the audit, there were 17 rest home level residents including one respite resident and 14 hospital level residents including one respite resident and two residents admitted under a young person with disability contract. All other residents were admitted under the aged related residential care contract. There are 27 dual-purpose beds and 5 rest home level beds.</p> <p>The service is delivered over two levels. On the top floor, there are 10 dual-purpose beds and on the day of audit there were 6 rest home and 4 hospital level residents in this area. The ground floor is divided into three wings. In one wing, there are nine rooms, five of which are rest home and four are dual-purpose. In this area on the day of audit there were three hospital level care residents - including one resident admitted under a young person with disability contract, and one resident admitted for respite care and six rest home level care residents. In the second wing, there are seven dual-purpose beds and on the day of audit there were three hospital and four rest home level residents – including one resident admitted for respite care. In the third wing, there are six dual-purpose beds, and on the day of audit there were four hospital level care residents - including one resident admitted under a young person with disability contract and one rest home level care resident.</p> <p>CHT has an overall business/strategic plan and Glynavon has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement.</p> <p>The unit manager is a registered nurse and maintains an annual practicing certificate. She has been in a management role at the facility for 23 years and continued as unit manager when CHT purchased the service. The unit manager reports to the area manager weekly on a variety of operational issues. The unit manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the unit manager, care staff and activities coordinator, cook, reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed and updated at the organisational level. New policies or changes to policy are communicated to staff, as evidenced in meeting minutes.</p> <p>Quality data collected is collated and analysed. Quality data is regularly communicated to staff via monthly staff meetings, and through the use of graphs that are posted on staff noticeboards. Quality data is benchmarked internally with other CHT sites.</p> <p>The internal audit programme which consists of two comprehensive six-monthly audits completed by the area manager is being implemented. Areas of non-compliance had corrective actions required are documented and shortfalls are addressed. There was evidence in the staff meetings to verify staff are informed of audit results. Examples since the last audit included (but were not limited to) resident satisfaction survey, and six monthly internal audit checks.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (unit coordinator) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed (last review March 2017).</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>FA</p>	<p>There is an accidents and incidents reporting policy. The unit manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality meetings including actions to minimise recurrence. A registered nurse conducts clinical follow-up of residents. Eight incident forms sampled (from a sample of resident files) demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Not all adverse events documented on an accident and incident form evidenced communication to families (link 1.1.9.1). Discussions with the unit manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A non-facility acquired pressure injury and an infectious outbreak in January 2017 were appropriately notified.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>FA</p>	<p>There are human resource management policies in place. These include that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (the unit coordinator, two registered</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>nurses, an activities coordinator and one healthcare assistant) and evidenced that reference checks were completed before employment is offered. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 is being implemented and includes all required training. The unit manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Three of the five registered nurses have completed interRAI training. Annual staff appraisals were evident in all staff files reviewed.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. In addition to the unit manager (a registered nurse), who works full time, there is one registered nurse on at any one time. The registered nurse on each shift is aware that extra staff can be called for increased resident requirements.</p> <p>On a morning shift, there are four HCAs (two full shifts and two five-hour shifts). On an afternoon shift, there are three HCAs (one eight-hour shift, one seven-hour shift and one four-hour shift). On nights, there is one HCA.</p> <p>Activities staff are rostered seven days a week. There are separate domestic staff who are responsible for cleaning and the laundry service is completed off-site.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>Ten medication charts were reviewed (four rest home - including one respite resident and six hospital including one young person with a disability). There are policies available for safe medicine management that meet legislative requirements. Residents' medicines are stored securely in the medication room/cupboard. The service uses an electronic medication management system. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had reviewed all resident's medication three-monthly and all allergies were noted.</p> <p>Only registered nurses administer medication, however not all registered nurses have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses robotic packed medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p>

		<p>There are no standing orders in use and there were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperature is recorded regularly and this is within the acceptable range.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All meals at Glynavon are prepared and cooked on-site by an external food service company. There is a food services manual in place to guide staff. The food service menu was last audited by a dietitian in April 2017. There is a four-weekly seasonal menu. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements by the RN. Food allergies and dislikes are listed in the kitchen. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. Cultural and religious food preferences are met.</p> <p>Meals are plated and served from the kitchen to the residents in the two dining areas. The plated meals are delivered via a hot box to the upstairs dining area. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Dry goods are stored in dated sealed containers. Chemicals are stored safely. Cleaning schedules are maintained. The dishwasher is checked regularly by the chemical supplier. All staff who work in the kitchen have completed or are currently completing their food safety course.</p> <p>There is specialised crockery such as lip plates and mugs and utensils to promote resident independence with meals.</p> <p>Residents have the opportunity to provide feedback on the menu and food services through the resident meeting and resident surveys. Residents and family members interviewed were very satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Click here to enter text
Standard 1.3.6:	PA	The RNs are responsible for all aspects of care planning. Interventions noted in discharge summaries were not

<p>Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>Moderate</p>	<p>always transferred to the care plans. In the files sampled, care plans did not always include interventions for all identified care needs and interventions were not all documented in sufficient detail to guide the care staff.</p> <p>Staff interviewed reported they found the care plans easy to follow and could describe the care required for the residents. Family/whānau members interviewed confirmed the care delivery and support by staff is consistent with their expectations. If external nursing or allied health advice is required, the RNs will initiate a referral (eg, to the district nurse [hospice nurse]). If external medical advice is required, this will be actioned by the GP.</p> <p>In the residents' files reviewed short-term care plans were commenced for all changes in health condition.</p> <p>Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>On the day of audit there were eight wounds. Wound assessment, monitoring and wound management plans are in place, however not all wound care documentation was completed for all wounds. The RNs have access to specialist nursing wound care management advice through the DHB.</p> <p>There was evidence of pressure injury prevention interventions such as two hourly turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p> <p>Interviews with registered nurses and healthcare assistants demonstrated an understanding of the individualised needs of residents. Staff could describe the components of appropriate Tikanga Māori and the components of safe cultural care for the five residents who identified as Māori.</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>Two activities coordinators are rostered to deliver the activities programme. On the day of audit, the service was actively recruiting to fill the vacancy created by a recent resignation. Care staff are currently supporting the delivery of the programme until the vacancy is filled. The programme operates seven days a week. Each resident has an individual activities assessment on admission, which is incorporated into the interRAI assessment process. An individual activities plan is developed for each resident by the activities coordinators in consultation with the registered nurses. Each resident is free to choose if they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include at least weekly planned visits to the community. All long-term resident files sampled have a recent activity plan within the care plan and this is appraised at least six-monthly when the care plan is evaluated or a further interRAI assessment occurs. Residents interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan was evaluated at least six-monthly or earlier if there is a change in health status. There</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>was at least a three-monthly review by the GP. Reassessments have been completed using interRAI LTCF and other relevant assessment tools for residents who have had a significant change in health status. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</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>A current building warrant of fitness is posted in a visible location (expiry 15 June 2018).</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>Infection surveillance is an integral part of the infection control programme and is described in CHT Glynavon infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at all staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the area manager. There has been one outbreak in January 2017, which was well managed.</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>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. There are five hospital residents requiring the use of restraints (two residents are using two restraints, bedrails and lap belts, and three residents are using bed rails). There are three hospital residents using an enabler (bedrails). The use of the enabler is voluntary. An assessment for restraint/enabler use and consent form were evidenced as completed in the three enabler and one restraint file reviewed. The enabler and restraint care plans reviewed did not state the risks associated with the use of restraint/enabler and did not document the interventions</p>

		<p>to manage the identified risks (link 1.3.5.2).</p> <p>Staff education on RMSP/enablers has been provided. Restraint has been discussed as part of quality meetings. A registered nurse is the designated restraint coordinator.</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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>The families interviewed advised they were informed of any adverse events or changes to their relative’s health condition. There is a space on the incident form to document whether (or not) family had been notified of an adverse event. Staff also record any communication with family in the progress notes as evidenced in the clinical files reviewed. However, five of eight incident forms reviewed had the communication with family section left blank and there was no documentation in the progress notes to confirm that family had been contacted.</p>	<p>Five of eight incident forms reviewed (three hospital and two rest home) did not evidence that family had been notified following an adverse event.</p>	<p>Ensure that family are advised of all adverse events.</p> <p>90 days</p>



<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Low</p>	<p>Only registered nurses administer medication at CHT Glynavon. Registered nurses are required to complete an annual medication competency, however not all registered nurses had completed the required annual competency assessment. The registered nurse who was assessing medication competency had also not completed an annual competency assessment.</p>	<p>i) Three of seven RNs that administer medication could not evidence an annual medication competency.</p> <p>ii) The unit coordinator that completes staff medication competencies last completed a medication competency assessment in 2015.</p>	<p>i-ii) Ensure that all staff that administer medication or who assess medication competency, complete the required annual competency assessments.</p> <p>30 days</p>
<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>	<p>PA Low</p>	<p>The registered nurses are responsible for all nursing assessments and the development of the care plan in the required timeframes. In two of five files reviewed (one rest home and one hospital) the assessments and care plans were not documented within the required timeframes.</p>	<p>i) One rest home resident admitted for respite care 18 days prior to the audit had not had all required risk assessments completed until the day of audit and the initial care plan was not documented until three days after the resident was admitted.</p> <p>ii) One of four long-term care residents (hospital) had not had the interRAI assessment or care plan documented within 21 days.</p>	<p>i-ii) Ensure all assessments and care plans are completed and documented within the required timeframes.</p> <p>60 days</p>
<p>Criterion</p>	<p>PA</p>	<p>The registered nurses' complete</p>	<p>i) Four of five care plans sampled did not have interventions</p>	<p>i) Ensure</p>

<p>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>	<p>Moderate</p>	<p>assessments to identify the care needs of the resident, and use this information to document a care plan. In all files sampled care plans were not documented for all care needs and where care plans were documented they were not always documented in sufficient detail to guide the care staff.</p> <p>Wound care plans were documented, however one hospital resident with four separate chronic wounds did not have a care plan documented for each wound.</p>	<p>documented for a) one hospital (tracer) resident for the management of mental health issues, and the medium falls risk b) one rest home resident (tracer) for the management of symptomatic atrial fibrillation, chronic kidney disease, and CHF, c) one hospital resident with type II diabetes and unstable blood sugars, mental health issues, and renal failure, d) one hospital resident for the management of angina, medium fall risk, wandering and PI risk. These files also lacked sufficient detail to guide the care staff in the management of behaviours, short-term memory loss, the risks associated with the use of restraint, and the specific monitoring required for signs of infection, constipation, GI bleeding and wandering.</p> <p>ii) In one of five files sampled (rest home tracer) the interventions documented in the discharge summary for daily weighs were not transferred to the resident's care plan and were not implemented.</p> <p>iii) Three of three enabler care plans and one of five restraint care plans reviewed did not state the risks associated with the use of restraint/enabler and did not document the interventions to manage the identified risks.</p> <p>iv) One hospital resident with four chronic wounds did not have a separate wound care plan for each wound, and each wound was not individually evaluated with each dressing change.</p>	<p>that care plans are documented for all assessed care needs and that that interventions are documented in sufficient detail to guide the care staff.</p> <p>ii) Ensure that interventions that are documented in discharge summaries are added to the care plan and are implemented.</p> <p>iii) Ensure that the risks associated with the use of an enabler or restraint are documented and interventions to manage the identified risks are</p>
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				<p>noted in the care plan.</p> <p>iv) Ensure that all separate wounds have a care plan documented and the wound is evaluated at each dressing change.</p> <p>60 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.