# Rosebank Residential Limited - Rosebank Home and Hospital

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Rosebank Residential Limited

**Premises audited:** Rosebank Home and Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 17 December 2018 End date: 18 December 2018

**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:** 85

# 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 |
|  | 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

Rosebank Home and Hospital is a privately-owned aged care facility. Rosebank Home and Hospital provides care to up to 110 rest home and hospital level residents. On the day of audit, there were 85 residents.

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

Residents and families interviewed were very complimentary of the care and support provided. The general manager and management team, including the education and quality and health and safety coordinator, are well qualified for their roles. The clinical coordinator is new to the role and has previous experience as a registered nurse at Rosebank.

The service has addressed three of five previous findings from the certification and partial provisional in relation to neurological observations, assessments and restraint monitoring. Improvements continue to require addressing around interventions and aspects of food safety.

This audit has identified further improvements are required in relation to communication of quality information, wound management, activities assessment, and medication management.

## Consumer rights

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| 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. |

Residents and family are well informed, including of changes in residents’ health. The facility manager and clinical coordinator have an open-door policy. Complaint forms and advocacy brochures are available. There is a current complaint register. Staff are aware of the complaints process and to whom they should direct complaints.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Rosebank Home and Hospital has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident and staff meetings. Incidents documented demonstrated immediate follow up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. The organisational staffing policy aligns with contractual requirements and includes skill mixes.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records were individualised and demonstrated service integration. Care plans are evaluated at least six-monthly. InterRAI assessment timeframes had been met. Resident files included medical notes by the general practitioner and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for administration of medicines complete education and medication competencies.

A diversional therapist coordinates and implements the activity programme for the residents. The programme includes community visitors, outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group.

All meals and baking are done on-site. Residents' food preferences and dietary requirements are identified at admission and accommodated. The menu is reviewed by the dietitian. Residents commented positively on the meals provided.

## Safe and appropriate environment

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| 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. |

The building holds a current warrant of fitness. Reactive and preventative maintenance occurs. Electrical equipment has been tested and tagged. Medical equipment has been calibrated. Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. External garden areas are available with suitable pathways, seating and shade provided.

## Restraint minimisation and safe practice

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| 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. |

There are documented and implemented policies and procedures around restraint use and use of enablers. There were no residents with restraint and two with enablers. Restraint audits, training and competencies for staff have been completed.

## Infection prevention and control

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

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel. Staff receive ongoing training on infection control. No outbreaks have been reported.

## Summary of attainment

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

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| **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 | 4 | 2 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 5 | 2 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
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| **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 | The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the facility manager using a complaint register. Documentation including follow-up letters and resolution demonstrates that complaints are being managed. All complaint responses were completed within the contractual timeframes in accordance with guidelines set forth by the Health and Disability Commissioner.  Discussions with the residents confirmed they were provided with information on complaints and complaints forms. Complaints forms are available. Twelve complaints received in 2018 and one from 2017 were reviewed with evidence of appropriate follow-up actions taken. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accidents and incidents are documented on a form that identifies if family/whānau have been informed (or not) of an accident/incident. Fourteen accident/incident forms reviewed identified family are kept informed. Six residents (three rest home and three hospital) interviewed, stated that they were welcomed on entry and were given time and explanation about the services and procedures. Two relatives (hospital) interviewed confirmed they were well informed. An interpreter policy and contact details of interpreters is available and used where indicated.  There are six-monthly residents’ meetings where any issues or concerns to residents can be discussed. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Rosebank Home and Hospital is privately owned and governed by a Board. The service provides care for up to 110 residents including 96 dual-purpose beds and 14 rest home beds in the studio apartment wing. On the day of the audit, there were 85 residents (45 residents at rest home level (including one respite) and 40 at hospital level (including one on an end of life contract). All other residents were on the age-related contract. There were three rest home residents in the studio apartments.  An experienced general manager (RN), who has been in the role for over 12 years, manages the service. The general manager reports monthly to the Board on a variety of management issues. The current strategic plan and quality and risk management plans are being implemented. The general manager receives support from a clinical coordinator who has been in the role for three months but has worked at Rosebank as an RN for three years. The general manager is also supported by an education coordinator, quality/health and safety/infection control coordinator, registered nurses and care staff. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | There is a 2018 and 2019 business plan, and a risk and quality plan. Quality and risk management systems are implemented with quality initiatives that reflect evidence of evaluation and positive outcomes for residents and/or staff. Interviews with the manager, clinical coordinator and staff (three caregivers, two registered nurses, and one diversional therapist) reflect their understanding of the quality and risk management systems that have been put into place.  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 Health and Disability Services (Safety) Act 2001. Policies and procedures have been reviewed and updated as required. New policies or changes to policy are communicated to staff.  The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents’ falls; infection rates; complaints received; restraint use; pressure areas; and medication errors. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Quality and risk data, including data trends, are discussed at quality meetings for managerial staff. However, there is no evidence of discussion at staff meetings. Corrective actions are implemented when required and are signed off by the general manager or quality and health and safety coordinator when completed. Monitoring of the quality and risk plan is through a series of meetings and reports. A monthly report is submitted to the Board, which includes copies of the registered nurse and quality meetings.  There is an implemented health and safety and risk management system in place including policies to guide practice. The service has a Health and Safety Committee with specific role responsibilities. Hazard identification forms and a hazard register are in place. Health and safety is included in the orientation and annual staff training programme. Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes incident and accident information reported by staff on a paper-based system. Incident and accident data is collected and analysed monthly (link 1.2.3.6). Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Management advise this has not been required since the previous audit.  A sample of 14 resident related incident reports for December 2018 were reviewed. All incident forms documented registered nurse review and follow up. This included neurological observations, and 24-hour post-falls checks and ongoing assessments. The previous certification audit shortfall has been addressed. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource management policies in place that include the recruitment and staff selection process. Relevant checks are completed to validate the individual’s qualifications, experience and veracity. Copies of current practising certificates are retained. Six staff files (one clinical coordinator, one registered nurse, two caregivers, one cook and one diversional therapist) were reviewed and evidenced that reference checks are completed before employment is offered. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme is being implemented. There is a robust system in place which evidences attendance at all in-service training sessions. Caregivers are encouraged to complete qualifications. The nursing staff attend external training provided by the DHB. Staff are appraised annually on their performance. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels guide, and human resource policies include staff rationale and skill mix. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. A staff availability list ensures that staff sickness and vacant shifts are covered. There is at least one registered nurse on duty at all times. All RN’s have a first aid qualification and seven of the twelve RN’s have completed interRAI training. The clinical coordinator works full-time, as does the manager. The manager and clinical coordinator rotate on-call cover. At the time of the audit, there were 85 residents in total across 2 wings (east and west) and the apartments (three rest home residents).  In the east wing with 30 residents (26 hospital and 4 rest home residents), there is a registered nurse on each shift. She is supported on morning shift by five caregivers (two short and three long). There are four caregivers rostered on afternoon shift (two long and two short shift) and there is one care worker on night shift.  In the west wing with 52 residents (14 hospital and 38 rest home), there is a full-time RN on morning and afternoon shifts. The RN is supported on morning shift by four caregivers (two long and two shorter shifts). There are three caregivers on afternoon shift (two long and one shorter shift) and two care workers on night shift.  In the apartment wing with 12 residents (including three rest home), there is a caregiver rostered on from 7:30am to 12:30pm and from 4:30pm to 8:30pm. Outside of these times, care is covered by staff in the adjacent east wing.  One full-time diversional therapist activity coordinator is supported by a second part-time activities coordinator and physiotherapist assistant. There are sufficient kitchen staff to meet service needs. A maintenance person is employed by Rosebank to attend to maintenance issues. There are designated staff employed to cover laundry and housekeeping.  Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Twelve electronic medication charts were reviewed and included six hospital (including one resident admitted under end of life contract) and six rest home (including one resident on a respite stay).  The medication management policies and procedures comply with medication legislation and guidelines. There are two treatment rooms, one in the east and one in the west wing. Medication fridge temperatures are checked and recorded weekly. Medicines are appropriately stored, however, not all expiry dates were in accordance with relevant guidelines and legislation. Medication administration practices complied with the medication management policy on the medication rounds observed. Medication prescribed is signed as administered on the electronic chart.  Registered nurses and senior caregivers administer medicines. All staff that administer medicines are competent and have received medication management training. The facility uses a robotically packed medication management system for the packaging of all tablets. The registered nurse on duty reconciles the delivery and documents this. All medication charts reviewed aligned with prescribing requirements. There was evidence of three-monthly medication reviews by the GP. All medication charts have photo identification. Allergies or nil known allergies were recorded. One resident self-administering their own medicines did not comply with the organisations requirements for residents who are self-medicating. Standing orders are not in use. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | PA Low | All meals at Rosebank are prepared and cooked on-site. All food services staff have completed training in food safety and hygiene and chemical safety. The service has a verified and audited food control plan. There is a four-week seasonal menu which has been reviewed by a dietitian. The kitchen is off the combined dining room for the facility. Meals are served from a Bain Marie. Food temperature is taken before serving. The cook interviewed was aware of resident dietary needs and has been notified of any changes. Resident likes and dislikes are accommodated, and cultural and religious food preferences are met. Specialised utensils and crockery are available for use to promote resident independence with meals.  Fridge, freezer and chiller temperatures are recorded on a daily monitoring chart; however, recordings are not consistently documented. Cleaning schedules are maintained. Chemicals are stored safely. Staff were observed to be wearing correct personal protective clothing. All foods in the fridges were covered and dated and this is an improvement on previous audit.  Residents interviewed state alternative choices are offered for dislikes and expressed satisfaction with the meals. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial support plan is developed with information from the initial assessment, medical and discharge information. The resident/relatives are involved in the development of the initial assessment. Risk assessment tools and the interRAI tool are used to identify the required needs and interventions required to meet resident goals. All resident files reviewed had paper-based and interRAI assessments in place. The education coordinator closely monitors interRAI compliance and recent reports identified all assessments were up to date. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Moderate | The six resident files reviewed identified that care plans were resident focused and individualised. Risk management protocols were well documented for a number of specific requirements including (but not limited to): weight loss, pressure injury care and falls. Care plans reviewed evidence multidisciplinary involvement in the care of the resident.  Short-term care plans (STCPs) are in use for changes in health status. STCP’s reviewed had been evaluated on a regular basis and signed off as resolved. However, ongoing interventions were not always transferred to the long-term care plan. There is evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist; physiotherapist; dietitian; and district nurses. The care staff advise that the care plans are easy to follow. Medical notes, allied health professionals’ entries, recordings, significant events and communication with families were well documented.  The files of two residents with pressure injuries (one grade II on a heel and one grade II on buttocks) were reviewed and identified short-term care plans had been implemented and included appropriate interventions to manage and prevent further injury. This is an improvement from the previous audit. However, not all files reviewed identified all required interventions had been documented. This remains a finding from the previous audit. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident’s condition changes, the RN will initiate a GP consultation. On interview, a GP confirmed that care provided is of a high standard and GPs are kept informed. Staff state that they notify family members about any changes in their relative’s health status. All five long-term care plans sampled, have interventions documented. Care plans have not always been updated as residents’ needs changed (link 1.3.5.2).  Resident falls are reported on accident forms and written in the progress notes.  Care staff state there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.  Wound assessment, wound management and evaluation forms are in place for all wounds. However, not all wounds were documented on individual wound assessment management plans. Wound monitoring occurred as planned. There is a total of 25 wounds (14 skin tears, 3 ulcers, 2 surgical wounds, 2 other and 4 pressure injuries (two grade I and two grade II). On interview, the RN advised she has accessed the wound care specialist advice as required.  Monitoring forms are in use as applicable, such as weight, vital signs and wounds. Neurological observations were monitored according to set timeframes. Behaviour charts are available for any residents that exhibit challenging behaviours. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | PA Low | The service continues to employ an experienced and qualified diversional therapist (DT) and activity assistant to coordinate and implement an integrated activities programme for the rest home and hospital residents Monday to Saturday. The activities staff are supported by a team of 28 volunteers. All volunteers complete an orientation which includes manual handling, Code of Rights information, sign confidentiality statements and are provided with a handbook. A well-attended volunteer meeting is held six-monthly.  The programme offers variety and interest with entertainment and outings. Residents were able to participate in a range of activities that were appropriate to their cognitive and physical capabilities. Community links are maintained with groups such as churches, pre-schools, RSA and inter-home get-togethers. One-on-one time is spent with residents who are unable or choose not to participate in group activities. The three-monthly resident meetings provide residents the opportunity to feedback on the activity programme. The activity team also make daily contact with residents.  Activity staff advised that assessments were completed on admission, however, this was not evident in all resident files sampled. Activity plans and care plans are reviewed at the same time, however, not all admissions evidenced completed activity plans. The DT maintains activity progress notes in the integrated files.  The DT attends regional meetings and on-site education. The DT and activity assistant have current first aid certificates. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The registered nurses evaluate all initial care plans within three weeks of admission. InterRAI assessments have been utilised in conjunction with the six-monthly reviews. Files sampled demonstrated that the long-term nursing care plan has been evaluated at least six-monthly or earlier if there was a change in health status. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing (link 1.3.5.2).  The family member interviewed confirmed they are informed of all changes and GP visits. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building holds a current warrant of fitness. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.  Electrical equipment has been tested and tagged. All hoists and scales have been checked and tagged. Hot water temperatures have been monitored randomly in resident areas and are within the acceptable range. Residents were observed moving freely around the areas with mobility aids where required. The external areas, courtyards and gardens are well maintained. All outdoor areas have attractive features and are easily accessible to residents. All outdoor areas have some seating and shade. There is safe access to all communal areas. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. Individual infection reports are documented for each infection. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data is displayed for staff on the infection control noticeboard in the staff office. The infection control programme is linked with the quality management programme through reporting and at Health and Safety/Infection Control Committee meetings. Annual infection control reports are provided.  There have been no outbreaks since the previous audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There are policies around the use of restraints and enablers that align with the standard. The clinical manager is the restraint coordinator. There are two hospital residents with a bedrail enabler. Staff have received training around restraint minimisation, the management of challenging behaviour and completed restraint competencies. Enablers are voluntary. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | There is no current use of restraint at Rosebank. Two residents with enablers in the form of bedrails had monitoring charts completed in documented timeframes. The previous partial attainment has been addressed. |

# 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.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.6  Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | The quality and health and safety coordinator is responsible for collecting adverse event data and implementation of the internal audit programme, as per the internal audit schedule. Quality improvement data is collected around falls, skin tears, infections, and other adverse events and the data is being trended and analysed. There is no evidence to support that staff are informed regarding the number and type of adverse events each month or around trends in data or what the data is reflecting. | Staff are not kept informed through meetings regarding adverse events data or trends. | Ensure that the trended and analysed quality data collected is shared with staff.  90 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Medication was stored in locked trolleys and locked medication rooms in each wing. Medications were checked regularly for expiry dates, however, on the day of audit not all cremes in the stock cupboard and all not all eyedrops on the medication trolley evidenced current dates. | i) The medication trolley in the east wing contained three eyedrops which were either undated or in use past the expiry date and three unused cremes in the stock cupboard were past expiry date. | i) Ensure all eyedrops are dated on opening and discarded on expiry and ensure all stock cremes are checked for expiry dates and discarded if past expiry date.  30 days |
| Criterion 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Residents who wish to self-medicate are provided with safe storage. An initial competency assessment is completed with reviews scheduled six-monthly. However, the one resident currently self-medicating had not had a review completed. | One rest home resident had an initial competency assessment completed but this had not been reviewed | Ensure medication competency assessments are completed as per policy.  60 days |
| Criterion 1.3.13.5  All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Food control plan documentation records include consistent temperatures of food at dishing. Fridge, freezer and chiller temperatures are recorded sporadically. All foods in the fridges were covered and dated and this is an improvement on previous audit. | Fridge and freezer temperatures have not been recorded consistently | Ensure fridge freezer and chiller temperatures are recorded daily as per food control plan documentation  90 days |
| Criterion 1.3.5.2  Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Moderate | The service has robust care protocols in place for specific areas of identified risk and staff interviewed were familiar with these. Four of six care plans evidenced that all care interventions were documented in care plans. STCPs were well documented and utilised for acute changes in health status. Evaluations were documented to reflect whether these have been resolved or updated in the LTCP if the interventions remain current. | i) One resident with a high falls risk had been signed out as transferred to the long-term care plan. However, the long-term care plan had not been updated to reflect the changes.  ii) One respite rest home resident had no interventions for management of diabetes or challenging behaviour. | Ensure that care plan interventions address all assessed risk and identified problems.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Wound management plans are implemented and managed as per documented instructions for all wounds. However, not all wounds were documented on individual forms and it was difficult to clearly identify progress of these individual wounds. | Four wound management assessment and plans included two or more separate wounds on the same chart | Ensure all wounds are documented on individual management plans.  90 days |
| Criterion 1.3.7.1  Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer. | PA Low | The diversional therapist completes an assessment on all new residents shortly after admission and from this develops an activity care plan. However, this had not been completed for all residents. | (i) There was no documented activities assessment on file for a resident admitted three months previously. (ii) There were no documented activities plan for two residents admitted three months previously (one rest home, one hospital) | Ensure all residents have an activities assessment and care plan completed as per policy.  90 days |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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| No data to display |

End of the report.