

McKenzie Healthcare Limited - McKenzie HealthCare

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: McKenzie Healthcare Limited

Premises audited: McKenzie HealthCare

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

Dates of audit: Start date: 10 July 2019 End date: 11 July 2019

Proposed changes to current services (if any): One previous dual-purpose bed has been decommissioned during a building project reducing bed numbers from 50 to 49 beds

Total beds occupied across all premises included in the audit on the first day of the audit: 41



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

McKenzie HealthCare provides rest home, hospital and dementia level care to up to 49 residents. On the day of the audit there were 41 residents.

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

The service is managed by a facility manager, who has been in the role for two weeks. She is supported in her role by two senior nurses/CSM and a staff educator/RN. Residents, relatives and the GP interviewed, spoke positively about the service provided.

The previous certification audits shortfall relation to aspects of wound management continues to require improvement.

This audit also identified further improvements required around the quality programme, incident reports, education and training for staff, service timeframes, evaluations and medication management.

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.
--	--	--

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

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.
---	--	--

McKenzie HealthCare has a documented quality programme. 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. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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>
---	--	---

The service utilises a paper-based system for managing all resident records. A registered nurse assesses and develops the care plan documenting support, needs, goals and outcomes with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and had been evaluated six-monthly. Resident files included review by the general practitioner, specialist and allied health services.

Two diversional therapists (one in training) and a part-time activities assistant coordinate the activity programme for the rest home, dementia and hospital residents. The programme includes community visitors and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. Residents are encouraged to maintain links with community groups.

Medication policies reflect legislative requirements and guidelines. Registered nurses are responsible for administration of medicines and complete medication competencies and annual education. The service has implemented an electronic medication system. The general practitioner reviews medications three-monthly.

Resident food preferences and dietary requirements are identified at admission and all meals are cooked on site. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Residents interviewed were complimentary about the food service.

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.
--	--	--

The service has a current building warrant of fitness and reactive and preventative maintenance occurs.

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.
---	--	--

The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were two residents with a restraint (one bed rail and one lap belt) and three residents using enablers (all bed rails). Staff training has been provided around restraint minimisation and enablers and management of challenging behaviours.

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.
---	--	--

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. There have been no outbreaks since the previous audit.

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	9	0	4	3	0	0
Criteria	0	36	0	6	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to resident/relatives at entry and is prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. There have been four complaints made since the last audit. Documentation, including follow-up letters and resolution, demonstrated that complaints are well managed. One of the four complaints was made through the Health and Disability Commissioner (HDC). This was resolved in January 2019 with the HDC, confirming in a letter that no further action would be taken. Discussion with residents and relatives confirmed they were provided with information on complaints and complaints forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. Residents (three hospital and one rest home) and family members (three hospital and one rest home) interviewed, stated they were welcomed on entry and given time and explanation about services and procedures. Twelve incident/accident forms were reviewed for the month of June 2019. There are documented bi-monthly resident/relative meetings each month with information regarding service discussed at meetings. Management have an open-door policy. Residents and family were advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services, residents and their family/whānau. If residents or family/whānau have difficulty</p>

communication.		with written or spoken English, then interpreter services are made available.
<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>McKenzie HealthCare is privately owned and is governed by a group of shareholders and company directors. McKenzie HealthCare provides rest home, hospital and dementia level care for up to 48 residents in a 43-bed rest home and hospital wing (all dual-purpose beds) and a six-bed dementia unit. One previous dual-purpose bed has been decommissioned during a building project reducing bed numbers from 50 to 49 beds. At the time of the audit there were 41 residents in total, 29 hospital level residents, eight rest home level residents (including one respite resident) and four residents in the dementia unit. All residents were under the age-related residential care (ARRC) contract. The facility is split into five units; Moore, Moginie, Burton, Scott (all dual-purpose) and Pines (dementia care) units.</p> <p>There is a documented 2017 – 2020 strategic/business and quality plan. The current facility manager (RN) has been in the role for two weeks. She is supported by the previous contracted acting manager and two senior nurses and a staff educator who has been in the position for three weeks.</p> <p>The facility manager (RN) has previously worked as a staff educator in an aged care facility and has completed at least eight hours of professional development, related to managing an aged care residential facility in the last year.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>McKenzie HealthCare has an established quality and risk management system. The service has policies and procedures, and staff are informed of updates and changes as confirmed on staff interview.</p> <p>The business plan and quality programme describe McKenzie HealthCare's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. Not all quality activities for 2018 and 2019 have been implemented. Quality assurance/management and staff meetings have not all been held as scheduled over the last six to eight months. There was evidence of discussion around quality activities for a meeting in June and on interview, staff stated they were aware of quality indicators; however, this was not evidenced on the day of audit. Resident/relative meetings have been held and minutes documented.</p> <p>Data is collected on complaints, accidents, incidents, infection control and restraint use. There is an internal audit schedule, which was completed as scheduled for 2018, however this has not been fully implemented for 2019. Areas of non-compliance identified through quality activities are actioned for improvement, however, not all corrective actions have been completed. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The hazard register has been reviewed annually. Resident surveys have not been completed since 2016.</p> <p>Falls prevention strategies are in place including intentional rounding, post-falls reviews, individual interventions</p>

		and the introduction of Wi-Fi mats and IPR fall sensors for frequent fallers to reduce the incidence of falls. Resident surveys have not been completed since 2016.
<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>	PA Low	The service documents and analyses all incidents/accidents. There is a multi-use form that can be completed for all hazards, near misses and incidents and accidents. Twelve resident related incident/accident forms were reviewed. Individual incident reports have been completed for each incident/accident, with immediate action noted. The incident/accident forms reviewed documented immediate follow-up by a RN including neurological observations for unwitnessed falls or falls with a possible head injury. Not all incident forms identified opportunities to minimise future events. Discussions with the facility manager, confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notification made since the last audit.
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>There are human resource management policies in place, which includes the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of the registered nurse's practising certificate is kept. Five staff files were reviewed, including two registered nurses, the diversional therapist and two healthcare assistants. None of the five staff files reviewed evidenced that full employment documentation was in place. The manager and assistant manager advised that an orientation programme is provided to new staff. All staff files reviewed had signed contracts and a signed job description, however not all files evidenced completed orientation documentation, an annual appraisal or ongoing training. The sample size was extended to nine to include new staff hired in 2019.</p> <p>The in-service education programme for 2018 and 2019 was not fully implemented. A competency programme is implemented for medication competent staff.</p> <p>There are 21 HCAs including those that work in the dementia unit. Seventeen dementia unit staff have completed the required dementia standards. The service does not allow staff to work in the dementia unit until they have completed the training. All registered nurses have an up-to-date first aid certificate. Four of eight RNs are interRAI trained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	FA	An organisational staffing policy aligns with contractual requirements and includes skill mixes. The facility manager works 40 hours per week and shares the 24/7 on-call duties with the senior nurses. There are at least two RNs on duty for the morning and afternoon shifts and one on the night shift. The facility is split into five units; Moore, Moginie, Burton, Scott (all dual-purpose) and Pines (dementia care) units. Moore, Moginie, Burton and

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>Scott are rostered together.</p> <p>The dual-purpose units (29 hospital and 8 rest home residents) are staffed by two registered nurses from 6.30 am to 3.15 pm. A third RN works from 9am to 6pm three days a week. The registered nurses are supported by seven HCAs (three full shifts and four short shifts). There is one RN rostered on afternoon shift supported by five HCAs (two full shifts and three shorter shifts). There is one RN and one HCA on night shift.</p> <p>In Pines (four dementia residents), there is one HCA on duty in the morning shift and afternoon shift, and night shift. The RNs from the dual-purpose units cover the Pines dementia care unit. Interviews with relatives and residents all confirmed that staffing numbers were appropriate. Healthcare assistants interviewed stated that they have sufficient staffing levels.</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 Moderate</p>	<p>McKenzie HealthCare's medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. In interview, the senior caregiver and assistant manager reported that a verification check is completed by the RN for medications delivered to the facility. All medications are stored securely in a locked room and locked medication trolleys. Short-life medications (ie, eye drops and ointments) are dated once opened. The controlled drug register was maintained and evidenced weekly checks and six-monthly physical stocktakes, however not all entries in the register identified the time of administration and two staff signatures.</p> <p>The service uses a medication software programme. All residents have individual medication orders with photo identification and allergy status documented. The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged.</p> <p>Education on medication management has occurred with competencies conducted for the registered nurses and senior healthcare assistants with medication administration responsibilities. Fourteen medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. No residents self-administer medicines; however, a policy is in place as needed.</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</p>	<p>FA</p>	<p>The head chef and a second cook are supported by AM and PM kitchenhands. All have current food safety certificates. The head chef oversees the procurement of the food and management of the kitchen. The menu has been approved by a dietitian and a verified food control plan is implemented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits.</p> <p>There is a well-equipped kitchen and all meals are cooked on site. Meals are taken to the three dining rooms in</p>

<p>is a component of service delivery.</p>		<p>hot boxes and served directly from these. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well-presented and residents stated that they were enjoying their meal.</p> <p>The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes were noted on individual coloured cards. There are snacks available at all times in the dementia unit. Residents and family members interviewed were very satisfied with the meals. Residents have the opportunity to feedback on the service through resident meetings.</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>	<p>PA Moderate</p>	<p>The care being provided for residents is consistent with the needs of the residents, as evidenced through review of resident files, interviews with staff and residents and observation of practice. Residents who required registered nurse review following health concerns, have this recorded as 'having been done'. Relatives were notified of changes in a resident's condition as evidenced in progress notes and family contact sheets. The registered nurse initiates a GP consultation for any changes in resident health status. Caregivers document any changes in care/condition of residents in the progress notes. The resident records reviewed were individualised and personalised to meet the assessed needs of the residents. The care was flexible and focused on promoting quality of life for the residents. All residents interviewed reported satisfaction with the care and service delivery.</p> <p>There were four current wounds on the day of audit including one chronic wound requiring at least daily dressings, a surgical wound, a skin tear, and a chronic ulcer. Registered nurses interviewed could describe access to wound specialist nurses if required. The GP reviews wounds three monthly or earlier if there are signs of infection or non-healing. Wound assessments, wound management plans, short-term care plans and wound progress reports has been completed, however not all plans evidenced dressings occurred as scheduled. Wound documentation continues to require improvement. There were adequate dressing and continence supplies sighted on the day of audit. Specialist continence advice is available as needed and this could be described by the RNs interviewed.</p> <p>On interview, staff confirmed they were familiar with the current interventions of the residents. Monitoring records are completed for weight, observations, behaviours, and food and fluids.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery</p>	<p>FA</p>	<p>McKenzie HealthCare employs three activity staff (one a diversional therapist, one diversional therapist in training and an activities assistant) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for five days per week with activities staff. Planned weekend activities are delivered by the healthcare assistants. The group activities programme is</p>

<p>plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>developed monthly, and a copy of the programme is available in the lounge and on noticeboards.</p> <p>The group programme includes residents being involved within the community with social clubs, riding for the disabled, churches and school. Exercises are provided three times a week. There is a separate programme for the dementia unit. The DT advised that this is a very flexible programme depending on the residents on a day-to-day basis. Residents have 24-hour activity plans incorporated in their care plans. Group activities are provided in the large communal dining room, in seating areas and outdoors in the gardens when weather permits. Individual activities are provided in residents' rooms or wherever applicable.</p> <p>Special events are celebrated with all residents receiving an individual cake of their choice on their birthday and a personalised card. The event is celebrated at shared morning or afternoon tea and photos of the resident with their cake are taken and given to the resident to display in their rooms. Other events have included Christmas and mid-winter Christmas celebrations and a community afternoon tea to meet the new manager.</p> <p>Residents are interviewed on or soon after admission and a social history is noted. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process (link 1.3.3.3).</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>The service has its own van and access to a locally run community van which can take two wheelchairs and two residents. The DT drives the van and has a current first aid certificate. Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Low</p>	<p>Timeframes in relation to care planning evaluations are documented. The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly. In interviews, residents and family confirmed their participation in care plan evaluations. Care plan evaluations reviewed for five of five files did not always record the degree of achievement to the intervention provided and progress towards meeting the desired outcomes. Activities care plans developed are reviewed six monthly. 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. There was recorded evidence of additional input from allied health, if this was required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 1 July 2020. The maintenance person works from 8am to 1pm five days a week and is available on-call as required. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment and functional testing of electric beds and hoists. Hot water temperatures in resident areas are monitored and stable between 43-45 degrees</p>

<p>provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>Celsius. Contractors are available for essential services. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. Residents were able to access the outdoor gardens and courtyards safely. Seating and shade is provided.</p> <p>Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans. The dementia unit has an accessible and secure outdoor garden.</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 and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff advised they are informed, although there is no documented evidence from meeting minutes (link 1.2.3.6). This data is monitored and evaluated three monthly and annually at infection control meetings.</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>Restraint practices are only used where it is clinically indicated and justified, and where other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were two residents with a restraint (one bed rail and one lap belt) and three residents using enablers (all bed rails). The three files for the residents using enablers reflects a restraint/enabler assessment and voluntary consent by the resident. Staff training on restraint and challenging behaviour management has not been provided since the previous audit (link 1.2.7.5).</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	The new manager is now responsible for the overall implementation of the quality programme. A quality plan for 2019 is in place. Quality activities have been conducted in 2018 and a plan is in place in 2019 to recommence internal audits, corrective actions (link 1.2.3.8) and discussion of quality information at staff meetings. Quality, management and staff meetings have not been held as scheduled in 2019. The service has not conducted a recent resident survey.	(i) Staff meeting minutes do not include discussion with staff around quality related activities and issues; and (ii) a resident survey has not been conducted in the past two years.	<p>(i)-(ii) Ensure that meeting minutes include discussion of quality outcomes at staff meetings and conducting an annual resident survey.</p> <p>90 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	<p>PA Low</p>	<p>Corrective actions are documented following internal audits. Outcomes and completion of the corrective actions have not been completed for all internal audits. The new manager has a corrective action plan to implement schedules as planned.</p>	<p>Corrective actions identified through meeting minutes and internal audits (medication, cultural spiritual, activities programme and staff training) have not been fully implemented or documented as completed and signed off.</p>	<p>Ensure that all corrective actions are documented as implemented and signed off when completed.</p> <p>90 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Low</p>	<p>Incident forms are completed for all adverse events and include evidence of RN review and appropriate immediate clinical treatment. Opportunities to minimise future events are not always documented.</p>	<p>Incident forms did not always identify opportunities to minimise future events.</p>	<p>Ensure all incident forms identify opportunities to minimise future events</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>There are policies and procedures to ensure human resource management processes provide assurance of safe and appropriate care, including annual performance appraisals and three-monthly reviews following commencement of employment. Three-month reviews were evident for long-serving staff, however new staff who required a three-month review did not evidence this had been completed. The new manager is aware of this gap and is planning to address it.</p>	<p>Four of six new staff files reviewed had not had a three-month review on employment.</p>	<p>Ensure that three-month reviews occur as per policy.</p> <p>90 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers</p>	<p>PA Moderate</p>	<p>The service has orientation processes in place including a buddy system for new staff members to work alongside more</p>	<p>Four of seven staff files reviewed do not</p>	<p>Ensure that all employment</p>

receive an orientation/induction programme that covers the essential components of the service provided.		experienced staff. The orientation package includes health and safety, infection control and familiarisation with policies and procedures. Three of seven staff files who would have completed orientation (two were employed within the last three months) evidenced that orientation packages and documentation have been completed.	evidence that orientation packs have been completed, including the cook, the registered nurse, a healthcare assistant and the manager.	documentation is completed and documented. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	An annual in-service programme is documented and includes all mandatory training, however not all mandatory required training has been provided. Topics provided include fire training and evacuation, continence and manual handling. Annual reviews were documented for one staff member, however two others who required review had not been completed. Two of six staff files are not yet due for an annual appraisal.	In-service education has not been provided for all staff including, code of consumer rights, restraint, cultural safety, chemical safety, falls prevention, restraint, challenging behaviour, abuse and neglect and infection control. Two of three long-serving staff did not have a current annual appraisal	Ensure all that all educational requirements are provided in-line with the annual plan. 60 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	PA Moderate	Controlled medications were stored securely. Medication competent staff checked the medications out, however a second signature and the time of administration were not always recorded.	(i) The times of controlled drug administration was not recorded on four occasions. (ii) The signatures of two staff in the controlled drug register were not recorded on two occasions	(i)-(ii) Ensure the controlled drug register is fully completed to evidence two signatures and the time of administration

guidelines.				30 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	Initial assessments and care plans are completed for all admissions. InterRAI assessments were completed for the four long-term residents, however not all required timeframes were met. The long-term care plans were completed on admission and six-monthly reviews have been completed.	<p>i) One of four residents (hospital level care) did not have an interRAI assessment completed within 21 days of admission.</p> <p>ii) Two of three residents who required follow-up six monthly interRAI assessments (one hospital and one dementia) did not have these completed within required timeframes.</p>	<p>Ensure all interRAI assessments occur within required timeframes.</p> <p>90 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	All wounds identified had a comprehensive wound care plan in place with reference to the wound in either a short-term or long-term care plan. This is an improvement on the previous audit. Wound management plans identified frequency of dressing, however not all dressing changes occurred as scheduled. One chronic malignancy that was not documented as dressed for a 10 day plus on occasions. Healthcare assistants and RNs interviewed were aware of residents with specific skin care needs. Neurological observations are completed for residents with unwitnessed falls.	One of four current wounds was not documented as dressed at least daily as scheduled in the management plan.	<p>Ensure that wounds are documented as re-dressed as identified in the wound management plan.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or</p>	PA Low	Care plans are reviewed six monthly by the registered nurse. Of the five files reviewed, two residents did not require a six-monthly evaluation (one respite and one new admission). Care plan evaluations did not evidence progress towards meeting goals.	Three of three files reviewed who had completed six monthly care plan reviews did not record progress towards meeting goals.	Ensure care plan reviews include progress towards meeting documented

intervention, and progress towards meeting the desired outcome.				goals. 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, 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.