

Prasad Family Foundation Limited

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:

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| Legal entity: | Prasad Family Foundation Limited |
| Premises audited: | Brylyn Residential Care |
| Services audited: | Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |
| Dates of audit: | Start date: 22 February 2018 End date: 23 February 2018 |
| Proposed changes to current services (if any): | |
| Total beds occupied across all premises included in the audit on the first day of the audit: | 24 |

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 |
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|  | 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 |
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| | 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

Brylyn Residential Care provides rest home and hospital level care for up to 30 residents and on the day of the audit there were 24 residents. The service is managed by a manager with the support of a senior registered nurse.

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.

The majority of residents and relatives interviewed spoke positively about the care and support provided. The service has made some improvements around establishing processes and systems.

The service has addressed 16 of 26 shortfalls from their previous certification audit. Further improvements continue to be required around policy reviews, aspects of the quality system, health & safety, training, care plan interventions, implementation of care, medication management, and environment.

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. |
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The service ensures effective communication with all stakeholders including residents and families. Complaints processes are implemented, and complaints and concerns are managed and documented.

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 medium or high risk and/or unattained and of low risk. |
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Under recent change of management quality and risk systems are being reviewed and implemented to support the provision of clinical care. Key roles are being allocated and meeting agendas are in progress to link with senior staff and staff meetings. An annual resident satisfaction survey is planned for March 2018 (the previous satisfaction survey was unable to be located) and regular resident meetings have commenced. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme. The staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

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| <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 are responsible for each stage of service provision. A registered nurse completes assessments, develops and evaluates the care plan with the resident and/or family/whānau input. Care plans viewed in resident records were reviewed at least six monthly. The General Practitioner reviews hospital residents monthly and Resthome 3 monthly and earlier as needed.

Medication policies reflect legislative requirements and guidelines. Registered nurses administer medicines. The medicine charts reviewed had allergy status identified. The medication charts had been reviewed at least three monthly.

An activity coordinator coordinates and implements the activity programme for the rest home and hospital level of care residents. The programme includes activities that met the individual and group preferences.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, additional requirements/modified needs and dislikes were being met.

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. | | Some standards applicable to this service partially attained and of low risk. |
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The building has a current building warrant of fitness, which expires 20 September 2018. Environmental improvements have been made since previous audit.

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. |
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents requiring enablers or restraint on the day of audit.

Infection prevention and control

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

Summary of attainment

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

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| Standards | 0 | 14 | 0 | 2 | 5 | 0 | 0 |
| Criteria | 0 | 38 | 0 | 4 | 5 | 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 |
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| <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>There is a complaints policy to guide practice and this is communicated to the resident/family member. The nurse manager leads the investigation and management of complaints (verbal and written). There is a complaints' register that records activity. Complaint forms are visible around the facility. There were nine documented complaints since October 2017. Follow-up letters, investigation and outcomes were documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p> | FA | <p>The service has an open disclosure policy. Discussions with three residents (one from the hospital and two from the rest home) and four family members (one hospital and three rest home) confirmed they were given time and explanation about services and procedures on admission. Resident meetings are planned to be held quarterly with the first under new management held December 2017 (evidenced by minutes) and the nurse manager has an open-door policy. This was evident on the days of audit.</p> <p>Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Sixteen accident/incident forms sampled from January 2018 identify that family were appropriately notified following</p> |

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| <p>conducive to effective communication.</p> | | <p>a resident incident. Interview with care staff confirmed that family members are kept informed.</p> <p>The residents and relatives interviewed confirmed family have been informed when the resident health status changes. The service has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</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>Brylyn Residential Care is a privately-owned facility. The service provides rest home and hospital level care for up to 30 residents. Ten of the beds are for dual use. On the day of the audit there were 15 rest home level and 9 hospital level residents. One resident was privately funded, the balance of the residents were on the ARRC contract.</p> <p>Brylyn Residential Care has a business plan which is principally focussed on meeting standards and health and safety legislation. Progress towards goals is reported by the manager to the directors.</p> <p>The nurse manager is a registered nurse and has been in the role since September 2017, although for the first two months she was required to undertake full rostered registered nurse duties. The nurse manager has prior aged care clinical management experience. The nurse manager is supported by a senior registered nurse who has been at the facility for some years.</p> <p>The newly appointed nurse manager is planning to attend eight hours of professional development activities related to managing a rest home and hospital in March 2018.</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> | <p>PA Moderate</p> | <p>Since the commencement of new management, work has been undertaken on the establishment and implementation of a quality and risk management system. On audit, the nurse manager demonstrated the necessary knowledge to undertake this (but was limited to) what could be achieved due to time resource. A number of findings from the previous audit relating to the quality and risk management programme has been addressed. The service has commenced reviewing policies, but the health & safety policy continues to require reviewing. There is now a policy review schedule and reviewed policies are communicated to staff.</p> <p>There is recent documented evidence that collection and communication of quality data have now commenced, however analysis, and trending of the data needs to further be established.</p> <p>An audit schedule has been commenced and to date, six audits undertaken as per schedule under new management. There was evidence of corrective action plans to address issues. Staff meeting minutes, clinical meeting minutes and interviews with healthcare assistants (HCAs) evidence that staff are informed of accident and incident trends, internal audit outcomes, infection trends and complaints. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes, and corrective action plans have been introduced.</p> |

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| | | <p>Infections and accidents/incidents are also being documented. The service has a health and safety management system, and this is coordinated by a HCA and the manager. Staff have received training in health and safety and the establishment of a number of health and safety processes has been met. A register for staff accidents has been established, health and safety audits are included on the new audit schedule and there is documented evidence that monthly health and safety committee meetings have commenced. Monthly meetings (including minutes) of the health and safety committee have commenced. Health and safety meetings include identification of hazards and accident/incident reporting and trends. Emergency plans ensure appropriate response in an emergency.</p> <p>Previous annual resident and relative satisfaction surveys could not be located and were scheduled to be undertaken along with the trending of quality data. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is compared to previous data collected on-site. Senior team meeting minutes include an analysis of incident and accident data and corrective actions. Accident/incident forms sampled from January 2018 included detailed registered nurse assessment and follow-up including change of interventions in care plans (link 1.3.5.2).</p> <p>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with</p> | PA Moderate | <p>There are human resource management policies in place, which includes recruitment. 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 fully reviewed (one caregiver, one RN, one cook, one activities officer and one cleaner). Also, a further four files were reviewed of non- New Zealand citizens. It was identified that all four had current work visas and this is an improvement on previous audit. Four additional staff files of staff who had commenced employment since July 2017 were checked for completed orientation's. All four had a role specific orientation completed on file. All fully reviewed files contained a current position description and employment agreements. One of five files fully reviewed did not have evidence of an annual appraisal, one had been completed and three were not yet due. New management has introduced a schedule to manage appraisals.</p> |

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| <p>good employment practice and meet the requirements of legislation.</p> | | <p>The previous audit findings relating to work permits and orientation to positions have been met. The service now has available an orientation programme that provides new staff with relevant information for safe work practice.</p> <p>Previous findings relating to having an education planner in place, providing training in abuse and neglect prevention, cultural awareness, advocacy, the management of wounds and pressure injuries and infection control have been met. However, training for the infection control coordinator and one cook has not yet occurred and this continues to be an area requiring improvement. Eight hours of staff development or in-service education has been provided annually. All individual records and attendance numbers are maintained.</p> <p>There is currently only one RN interRAI competent. A second interRAI competent RN had been employed and is commencing in March 2018. Competencies completed by staff included handwashing, medication administration/checking, lifting and transferring</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a documented roster that provides coverage that meets requirements of the ARRC agreement. The recently appointed manager has been working in the management role full time since November 2017. Caregiving hours have increased on the afternoon shift. This is an improvement on last audit. There is at least one registered nurse on duty on each shift to cover the service 24/7.</p> <p>There are extra staff that can be called on for increased resident requirements if needed and the HCA short shift can be extended to a long shift if resident demands dictate. Interviews with HCAs, residents and family members identify that cares are being delivered, however, staff and management stated they are very busy particularly on morning duty and at weekends when there is no activities officer to assist with residents, and care staff do all laundry.</p> <p>On the morning duty one HCA is working 6.45 am to 1.30 pm and the other HCA until 3.00 pm. There is one RN on duty. There is a cleaner on duty Monday to Friday mornings, but all laundry is undertaken by HCAs. On afternoon duty there is one HCA on 2.45 pm to 9.00 pm and another 2.45 pm to 11.00 pm. There is one RN on duty. At night there is one RN and one HCA. The above staffing observed at audit was for 15 residents assessed as rest home level and nine residents assessed at hospital level.</p> <p>The nurse manager undertakes all quality duties, receptionist duties (there is no administrator or receptionist) and assists with care delivery</p> |
| <p>Standard 1.2.9: Consumer Information Management</p> | <p>FA</p> | <p>The previous findings relating to resident information of a private or personal nature being maintained in a secure manner and that resident information is not visible by other residents or the public have been addressed. There are now cabinets provided for secure storage and information of a personal nature has been removed out of view of</p> |

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| Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | | residents/relatives. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Residents entry into the service is facilitated in a competent, equitable, timely and respectful manner. Pre-admission information packs are provided for families and residents prior to or on admission. The revised admission agreement sighted aligns with all contractual requirements. The previous finding has been addressed. |
| 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 | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses have completed medication competencies. Education around safe medication administration has been provided 2017. Medications are delivered in blister packs and all medications are stored safely. The RN checks the medications against the medication chart and signs the signing sheet. Standing orders are not used and all medications are prescribed for the resident, however there were medications in stock for residents no longer at the service. The service holds an impress stock including antibiotics and some medications had expired. There were no residents self-medicating on the day of audit. All eye drops are dated on opening. The medication fridge is monitored daily, and the temperatures recorded were within the acceptable range.</p> <p>Ten pharmacy generated medication charts were reviewed (four hospital and six rest home). All charts had an allergy status identified, however not all charts had photo identification. There were duplicate medication charts (previous and reviewed) being held in the medication folder. All signing sheets corresponded with current medication charts. The GP has reviewed the medication charts three monthly. 'As required' medications had indications for use. The previous finding around medicine management remains.</p> |
| Standard 1.3.13: | PA Low | All meals and baking are prepared and cooked on-site by cooks. The cooks commence duty at 7.30 am to 5.30 pm |

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| <p>Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p> | | <p>and prepare breakfast, lunch and dinner. There is a four-week summer menu in place which has not been reviewed by a dietitian within the last two years. The midday and evening meal provided on the day of audit followed the menu plan. Meals are served directly from the kitchen to residents in the dining room. The cook receives a resident dietary profile. Dietary needs with individual likes and dislikes are known. The cook (interviewed) confirmed alternative options were provided as required. Modified meals (pureed) are listed on the menu plan and provided. There were adequate foods sighted in the pantry, refrigerator and freezer. There were gluten free food items sighted including Weetbix, flour, rice and rice milk.</p> <p>Fridge, freezer, dishwasher and end cooked meat temperatures are monitored and recorded daily. Many packets of spices had expired, and decanted dry goods did not have expiry dates on the containers. Not all food service staff have attended food safety training (link 1.2.7.5). The service is currently working on their food control plan.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>PA Moderate</p> | <p>Resident lifestyle plans reviewed were resident-focused and individualised for one of five resident files reviewed. Spiritual, cultural and recreational preferences and supports/needs were incorporated in the lifestyle plans reviewed. Short-term care plans were used for short-term needs such as weight loss. Lifestyle plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration and evidence of allied health care professionals involved in the care of the resident such as the GP, physiotherapist and dietitian.</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>When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications were documented on the family/whānau contact sheet in the resident files.</p> <p>Wound assessments, treatment and evaluations were in place for four residents with current wounds (skin tears) and one stage one facility acquired pressure injury of the heel. There is adequate pressure prevention injury equipment available. The RN interviewed was able to describe the referral process for a wound care nurse specialist if required.</p> <p>Continance products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly. Incident forms were reviewed of two residents that required neuro obs following a potential head injury. These were fully completed, and this is an improvement on previous audit.</p> <p>Monitoring occurs for weight, vital signs, blood glucose, wounds, continence and three hourly positioning charts.</p> |

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| | | Monitoring charts were not fully completed where required. |
| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | FA | <p>The service employs an activities coordinator for 25 hours per week Monday to Friday to provide an integrated rest home and hospital activity programme. The activity coordinator attends on-site in-service as available and has a current first aid certificate.</p> <p>Activities are held in the main lounge and were observed to occur as per the programme on the days of audit. Activities that meet the abilities of all residents include daily exercises, newspaper reading, board games, gardening, memory lane, knitting, supervised walks and wheelchair walks outside and quizzes. One-on-one time such as chats, nail care, hand massage and reading are spent with residents who choose not to join in group activity, or are unable to participate in activities. Entertainers providing entertainment and music attend the home every three weeks and for special occasions. The service does not have a van for outings and have previously hired a disability van, although outings have not yet occurred for 2018. Interdenominational church services are held on-site fortnightly with a monthly communion.</p> <p>An activity assessment and plan are incorporated in the RN assessment on admission and reviewed six monthly by the activity coordinator. Attendance lists are maintained. There is a resident meeting three monthly.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | FA | <p>Initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term lifestyle plans had been evaluated at least six monthly or earlier for any health changes. The interRAI assessment and lifestyle care plan had been completed earlier for one rest home resident due to significant changes in health requiring re-assessment to hospital level of care. The written evaluation is documented on the lifestyle care plan against identified goals. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes. Short-term care plans reviewed were current. The previous finding around short-term care plan evaluations has been addressed.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from</p> | FA | <p>Documented processes for the management of waste and hazardous substances are in place. Safety datasheets are available for staff Chemicals were stored safely, and all chemical bottles had manufacturer labels on them. The previous findings have been addressed.</p> |

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| harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | | |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | The building holds a current building warrant of fitness, which expires 20 September 2018. Reactive and preventative maintenance occurs. Resident and environmental equipment that required repair had been secured/protected by an electrician. Electrical tests had been undertaken. Hand washing stations met infection control standards. Carpet that had been damaged had been secured. These aspects of the previous finding have been met. The dining room vinyl remains split in several areas and this continues to require addressing. Since the onsite audit the service has provided feedback that this has been resolved and is now covered with a thin metal plate |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The roster reviewed evidenced each shift was covered by a minimum of one staff member who holds a current first aid certificate. There was documented evidence of a six-monthly trial evacuation along with booking evidence for the next. Residents had access to call bells they could operate (including in toilets). The previous findings have been addressed. |
| Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that | FA | Policies and procedures document infection prevention and control surveillance methods. Systems are in place and are appropriate to the size and complexity of the facility. The infection control coordinator collates infection control events monthly, however the data is not consistently analysed for trends and opportunities for improvement and training opportunities. Acute care plans are completed for all infections. Infection control internal audits have been completed. Infection rates have been low. There is no documented evidence of trending since May 2017 (link 1.2.3.6). There have been no outbreaks since the previous audit. |

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| have been specified in the infection control programme. | | |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | <p>There is a restraint minimisation and safe practice policy applicable to the service that complies with the Restraint Minimisation and Safe Practice Guideline 2008. The organisational policy for restraint minimisation and enabler use ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register.</p> <p>On the day of audit there were no residents using restraint or enablers. Staff interviews, and staff records evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</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) |
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| <p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p> | PA Low | In September 2017 with the commencement of new management, a documentation, management and review policy was introduced along with a review schedule. There was evidence that to date, three policies had been reviewed as per schedule and they had been communicated to staff with staff recording this had occurred. These aspects of the previous finding have now been addressed, however, the health and safety policy had not been reviewed. | The position descriptions attached to the health and safety policy had been reviewed as per the policy but the policy itself had not been reviewed. | <p>Review health and safety policy annually as per policy.</p> <p>90 days</p> |
| Criterion 1.2.3.6 | PA | The service has commenced | Two aspects of the previous audit finding remain open. | Recommence trending |

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| <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p> | <p>Moderate</p> | <p>establishing the quality and risk management system. Aspects of the previous audit finding have commenced being addressed. Communication of quality improvement data was signed in the recent staff meeting (January 2018). An audit for wound management is on the audit scheduled and undertaken September 2017. Communication of internal audit results has now been commenced.</p> | <p>Trending of quality data stopped in May 2017. The manager is aware of this and time permitting will recommence trending. The results of the resident satisfaction survey December 2016 could not be located to communicate to residents. New management is undertaking a resident survey in late February 2018.</p> | <p>and analysis of quality improvement data and undertake a resident satisfaction survey and convey results to residents/families.</p> <p>90 days</p> |
| <p>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.</p> | <p>PA Moderate</p> | <p>The service has an annual education planner that has scheduled education to cover the requirements of the Age-Related Resident Contract. Topics outlined on the schedule have been delivered. However, the infection control coordinator had not undertaken required training for the role and one of the cooks had not undertaken food safety training</p> | <p>The infection control coordinator had not undertaken required training for the role and one of the cooks had not undertaken food safety training.</p> | <p>Ensure education is provided to cover all contractual and legal requirements.</p> <p>90 days</p> |
| <p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing,</p> | <p>PA Moderate</p> | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Ten pharmacy generated medication charts were reviewed (four hospital and six rest home). There were injectable medications in stock that were named for a resident no longer at</p> | <p>(i) Twelve packets of injectable medications (including three packets of restricted medications and two packets of insulin) were in stock for a resident no longer at the service. (ii) Two bottles of tablets and one packet of suppositories had expired. (iii) Three long-term residents did not have photo identification on the medication charts. (iv) Older and recently reviewed medication charts were in the medication folder for four of ten medication charts reviewed.</p> | <p>(i) Ensure medications are returned to the pharmacy when a resident decease or leaves the service. (ii) Ensure all medications held are within the expiry dates. (iii)</p> |

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| administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | | the facility. There were expired medications. Not all medication charts had photo identification. Reviewed and older medications charts were held in the medication folder. | | Ensure all medication charts have photo identification. (iv) Ensure only the current medication chart is made available in the medication folder. 30 days |
| Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group. | PA Low | The menu is a four-week rotating seasonal menu and includes a pureed menu plan. The last review was two years ago. | The current menu plan in the kitchen has had changes made to meet resident preferences. These changes made within the last two years have not been reviewed or approved by a dietitian to ensure the nutritional needs of the residents are met. | Ensure there is a dietitian review/audit of the menu to ensure the residents nutritional needs (including serving portions) are met. 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 | There is sufficient storage area for food items. All dried goods in the pantry were in sealed bags or containers. Not all dried food containers had expiry dates and there were expired spices. The fridge, freezer and dishwasher temperatures are monitored daily. There are records of end cooked temperatures of meats. | (i) Some dried food items had been decanted into sealed containers, however there were no expiry dates on the containers. (ii) There were eight packets of spices that had expired outside of their best before dates. | (i) Ensure decanted foods have expiry dates on the containers. (ii) Ensure foods in use have not expired. 60 days |
| Criterion 1.3.5.2 | PA | Lifestyle plans are developed in | Four of five lifestyle plans (two hospital and two rest | Ensure lifestyle plans |

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| <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p> | <p>Moderate</p> | <p>consultation with the resident/relative. Information used from assessments, GP medical notes and discharge summaries is used to describe the required support/interventions to meet the resident needs. One of five resident lifestyle care plans fully described the resident supports required to meet the resident goals. The previous finding remains.</p> | <p>home) did not reflect the resident current interventions and needs/supports for the following; (i) One rest home resident care plan had not been updated to reflect pain management for knee pain and swelling as identified in GP notes, (ii) The care plan for another rest home resident did not reflect interventions for high falls risk and pressure injury prevention, as identified in the interRAI assessment, (iii) Pressure injury interventions had not been updated in the care plan for a hospital resident (link hospital tracer) and (iv) There was no therapeutic pain management regime in the care plan as identified in the interRAI assessment, for another hospital resident.</p> | <p>reflect the resident's current needs/supports to meet the resident goals.</p> <p>60 days</p> |
| <p>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.</p> | <p>PA Moderate</p> | <p>Nutritional requirements and assessments are completed on admission. Residents are weighed monthly, however residents with weight loss did not have more frequent weights or supplements administered as the short-term care plan interventions. The previous finding around interventions remains.</p> | <p>(i)There were no weekly weights taken for three residents (two rest home and one hospital) with weight loss. (ii) For two rest home residents there is no documented evidence of supplementary fortisip administered as documented in the short-term care plans.</p> | <p>Ensure interventions are implemented for residents with weight loss as documented in the short-term care plans.</p> <p>60 days</p> |
| <p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p> | <p>PA Low</p> | <p>Resident and environmental equipment that required repair had been secured/protected by an electrician. Electrical tests had been undertaken. Hand washing stations met infection control standards. Carpet that had been damaged had been secured. These aspects of the previous finding have been met. The dining</p> | <p>The dining room vinyl remains split in several areas. This matter in the previous finding remains open. Since the onsite audit the service has provided feedback that this has been resolved and is now covered with a thin metal plate.</p> | <p>Ensure flooring in dining room is safe for residents and staff and that it meets infection control standards.</p> <p>90 days</p> |

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| | | room vinyl remains split in several areas and this continues to require addressing. | | |
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.