# Waihi Senior Citizens Home Incorporated - Hetherington House

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](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:** Waihi Senior Citizens Home Incorporated

**Premises audited:** Hetherington House

**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: 20 June 2018 End date: 20 June 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:** 46

# 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

Hetherington House (Waihi Senior Citizens Home) is owned and operated by a community charitable trust. The trust is overseen by a board of trustees consisting of 10 members. The facility provides care for up to 50 residents offering rest home, hospital, and secure dementia care.

The service is managed by a facility manager who is an ex-registered nurse who has 30 years’ experience in aged care. The facility manager was appointed in February 2018.

Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family members, the manager, staff, and a general practitioner.

This audit has identified areas for improvement relating to human resources management, assessment and care plan timeframes and medication management documentation. Improvements have been made to activity planning and fire evacuation, addressing those areas requiring improvement at the previous audit.

## 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. |

Open communication between staff, residents and families is promoted and confirmed to be effective. There is access to formal interpreter services if required. A complaints register is maintained with complaints resolved promptly and effectively.

## 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 low risk. |

Business and quality and risk management plans include the core values, purpose and direction of the service. Monitoring of the services provided to the board of trustees is regular and effective. An experienced and suitably qualified person manages the facility.

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

The appointment and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes individual performance reviews. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

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

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery.

All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident’s needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents’ nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## 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. |

There is a current building warrant of fitness. The fire evacuation approved plan is in place and all fire equipment has been checked.

## 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 organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers and two restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infections. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

## 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 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 36 | 0 | 3 | 0 | 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](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).

|  |  |  |
| --- | --- | --- |
| **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/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register reviewed showed that 26 complaints/concerns of a minor nature have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Fifteen of the complaints are from one resident who had no complaints on the day of audit. Action plans show any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. She verbalised her understanding of the process as sighted in policy. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. This was confirmed in the complaints register sighted.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff know how to access interpreter services, although reported this was rarely required due to all residents able to speak and understand English. Staff support residents in the service who identify as Maori to integrate their cultural values and beliefs, however there were no residents who affiliate with their Maori culture at the time of audit. There is one resident who has a significant sensory impairment and appropriate resources and equipment have been implemented to support the resident to maintain their independence. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The strategic and business plans, which are reviewed annually, last reviewed in September 2017, outline the purpose, core values, direction and goals of the organisation. The documents described annual and longer term (10 year) objectives and the associated operational plans. A sample of monthly reports to the board of trustees showed adequate information to monitor performance is reported including financial, occupancy, maintenance and improvements, quality data, staff education, complaints and human resources matters. Health and safety issues are also discussed. Three board members sit on the health and safety committee and present any issues or emerging risks identified to the full board. The facility manager meets with either the chairman of the board or a nominated board member on an informal weekly basis to discuss any issues or concerns. The service is managed by a facility manager who holds relevant qualifications (level five (NZQA) diploma in business management) and has been in the role since February 2018. The Ministry of Health were notified of the change of manager. Soon after accepting the role, the facility manager was off work for health reasons for nine weeks and has only been active in the role for six weeks. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager has worked in aged care for 30 years and attends age care conferences and undertakes ongoing manager education. The facility manager was a registered nurse but they have not kept their registration current. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements. The service holds contracts with Waikato District Health Board (WDHB) for hospital, rest home, respite, end of life and dementia care services and with Ministry of Health (MOH) for residents who are under the age of 65 years. At the time of audit, there were 46 residents at the facility. Forty-five residents (29 rest home, 10 hospital and 6 dementia care) were receiving services under the Age Related Residential Care contract and one resident was receiving services under the End of Life Contract. There were no residents under the Residential non-aged MOH contract, Residential Respite Care (WDHB), or Long-Term Support Chronic Health Conditions (WDHB) at the time of audit. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, monitoring of outcomes, clinical incidents including infections, wound care, pressure injuries and falls. Meeting minutes reviewed confirmed regular review and analysis of quality indicators. Related information and outcomes are reported and discussed at the board meetings, and staff meetings. Staff reported their involvement in quality and risk management activities through implementation of corrective actions and audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. For example, there was an increase in medication errors in March 2018 which was followed up with a full clinical review by the GP and staff were reminded to followed safe medication management protocols. Each medication error was investigated. Staff reported that resident and family satisfaction surveys are completed annually. The most recent survey undertaken in 2017 was not located on the day of audit. Minutes from residents’ meetings were sighted and they showed that any issues raised are followed up accordingly. This was confirmed during resident and family interviews. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The board of trustees are actively involved in the health and safety committee and oversee all actions. This was also identified in the risk register sighted.  |
| 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 | Staff document adverse and near miss events on an accident/incident form. A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the facility manager and to the board of trustees. The facility manager and senior registered nurse described essential notification reporting requirements, including for pressure injuries. They advised there have been two notifications related to stage three pressure injuries made to the MOH under section 31 reporting since the previous audit. Both were non-facility acquired, one on 19 July 2017 and the second on 23 July 2017. One resident who went missing from the facility for two hours, was then returned to the facility by a member of the public. The internal investigation has been documented. The police were notified, but the resident returned before the police actioned the incident. This was not notified to the MOH at the time, but the facility is now aware that this is a requirement and a copy of required notifications have been placed in required procedures. There have been no police investigations, coroner’s inquests, issues-based audits and any other notifications since the previous audit.  |
| 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.  | PA Low | Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation’s policies are not being consistently implemented in relation to annual staff appraisals and orientation documentation.Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Of the seven staff files reviewed, three staff who commenced prior to 2010 had no orientation records and two more recently employed staff members (2016 and 2018) had no record of orientation. Two of the seven files had overdue staff performance appraisals. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. There are four trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training for interRAI with annual appraisals.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). Staff confirmed the facility adjusts staffing levels to meet the changing needs of residents. The staffing levels matched the need identified on the interRAI acuity data report sighted. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Most care staff reported there were adequate staff available to complete the work allocated to them. One staff member stated that it would be good to have another staff member on to assist with giving out breakfast. This was not supported by the other caregivers interviewed. Residents and family interviewed had no concerns around staffing numbers. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.There are dedicated rostered staff for the dementia unit. The diversional therapist, administrator, facility manager and senior registered nurse work Monday to Friday. The facility manager is on call for non-clinical matters and the senior registered nurse for clinical issues. Dedicated kitchen, laundry and cleaning staff work seven days a week.  |
| 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 Low | The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.A safe system for medicine management using a paper-based system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Good prescribing practices noted include the prescriber’s signature and date recorded on the commencement of medications; however, not all discontinuation of short term medicines were signed off by a GP and not all pro re nata (PRN) medicines had a reason stated for administering the medication. The required three-monthly GP review was recorded on the medicine chart, except for two residents. In these cases, evidence was sighted in the residents’ folders showing that the GP had completed an up to date three monthly review. Standing orders are used and were current and comply with guidelines. There were no residents self-administering medications at the time of audit. There is a process for any medication errors. A corrective action plan was sighted at the time of audit for medication errors and was followed up by the senior registered nurse. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The food service is provided on site by a kitchen manager, another two cooks and supported by kitchen staff, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The facility was issued with a food safety guide certificate and an A grade pass on the 24th April 2018. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager interviewed has undertaken a safe food handling qualification.A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Evidence of resident satisfaction with meals was verified by resident and family interviews and in residents’ meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident’s individualised needs was evident. The ‘house doctor’ interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a very good standard. Staff interviewed confirmed that they knew the residents well and care was provided as needed, however not all interRAI and long-term care plans were up to date and reflected residents assessed needs and desired outcomes (Refer criterion 1.3.3.3). A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | The activities programme is provided by a trained diversional therapist. The diversional therapist, along with the support of regular volunteers, support residents from Monday to Friday 8 am – 4.30 pm. A social assessment and history is undertaken on admission to ascertain residents’ needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident’s activity needs are evaluated three monthly and as part of the formal six- monthly care plan review. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Several residents are independent and encouraged to connect and interact with the community, while other residents are supported by the staff and groups in the community to partake in regular community activities and groups. Many of the activities provided at the facility support the coming together of all three services daily. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and day to day discussions. Residents interviewed confirmed they find the programme interactive and fun. The previous audit identified an area for improvement to ensure that all residents in the dementia unit had a 24-hour activity care plan to support residents with behaviours that may be challenging. This corrective action is now address with records available demonstrating these care plans in all five files reviewed in the dementia unit. Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes one to one activities, music and distraction.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. The interRAI assessment is seen as the formal care plan evaluation that occurs every six months or as residents’ needs change; however, not all interRAI and long-term care plans were up to date (Refer criterion 1.3.3.3). Where progress is different from expected, the service responds by initiating changes to the plan of care and there is evidence of working documents throughout the fifteen residents’ files reviewed. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, skin tears, falls and challenging behaviours. When necessary, and for unresolved problems, long term care plans are added to and updated. Families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness, which expires on 14 March 2019, is publicly displayed.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | The previous audit identified that this was an area for improvement. It is now fully attained as the current fire evacuation plan was approved by the New Zealand Fire Service on the 12 September 2016 which included the extension of the dementia unit. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 04 December 2017 and the next fire drill is scheduled for 27 June 2018 as confirmed in documentation sighted. Fire equipment was checked in July 2017 by an approved provider. The staff orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed.Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Thirty-nine (39) residents and 13 staff consented to having the flu vaccine in April 2018. The facility has had a total of 16 infections since January 2018. Surveillance data did not identify any residents who had frequent infections, however residents have been identified with an increased risk of infections due to co-morbidities. Short term and long-term care planning was sighted showing interventions to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation’s policies, procedures and practice their role and responsibilities. On the day of audit, two residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. Consent was sighted in the residents’ files and the six monthly reviews are undertaken by the GP and restraint coordinator with the resident and next of kin. The service has decreased the use of restraint from December 2017 when they had five restraints and two enablers.Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff. |

# 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)** |
| Criterion 1.2.7.4New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | New service providers confirmed they receive an orientation which covers the essential components of service delivery. Staff stated that they are ‘buddied’ with a senior staff member when they commence ‘on the floor’ and that longer orientation is given should it be required. Of the seven staff records reviewed, two staff who have been employed in the previous two-year period did not have completed orientation records in their staff file. Two of the files reviewed showed that these staff were overdue for their annual performance appraisals. One was due in December 2017 and the other in December 2015. The facility manager was working on developing a spread sheet to identify staff ‘due dates’, so this situation can be better managed.  | Not all staff files contained completed orientation information and not all staff annual appraisals are up to date. | Provide evidence that all newly employed staff have a completed orientation and that staff appraisals are undertaken at least annually. 180 days |
| Criterion 1.3.12.1A 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 Low | A safe administration medication round was observed during the audit. All required three-monthly GP reviews were up to date. Five residents had six (in total) short term medications charted on the drug chart however once the medication administered reached its end date the medication had been not signed of as completed by the GP. Two residents had three (in total) pro re nata (PRN) medications prescribed with no reason stipulated for use. | Not all medication charts had short term medications signed off by a GP when completed or reason stated for use for in the use of pro rata nata (PRN) medications. | Provide evidence that all short-term medication once administered and reached its prescribed end date is signed off by the GP. Pro rata nata (PRN) medication are documented in the medication chart as required to meet medication guidelines.90 days |
| Criterion 1.3.3.3Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | Staff interviewed stated that they knew the residents very well and were able to identify and meet their needs. Residents and family members interviewed stated that they were very happy with the care provided. There are four interRAI trained registered staff. The interRAI database identified eight interRAI assessments overdue. One assessment was due in February, one in April and six in May; however, on further investigation all but three of those interRAI assessments had been commenced but remained in draft as not fully complete. The three interRAI assessments not yet commenced were due in May. At the time of audit, nine interRAI assessments are due to be completed for the current month of June. Five long term care plans were not up to date. Two residents admitted in March and May of 2018 had initial short-term care plans but no long-term care plan. Three residents last had their long-term care plans updated in November of 2017.  | Not all residents had an up to date interRAI assessment or long-term care plans. | Ensure that all interRAI assessments and long-term care plans are completed with the required timeframes.180 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.

|  |
| --- |
| No data to display |

End of the report.