Oceania Care Company Limited - Melrose Rest Home and Retirement Village

Introduction

This report records the results of a Partial Provisional 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 Central Region's Technical Advisory Services 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:	Oceania Care Company Limited
Premises audited:	Melrose Rest Home and Retirement Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 October 2018 End date: 19 October 2018

Proposed changes to current services (if any): New build of 81 dual purpose beds

Total beds occupied across all premises included in the audit on the first day of the audit: 69

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.

General overview of the audit

The Bayview, formerly Melrose Rest Home and Retirement Village, is currently able to provide rest home and hospital level of care for up to 79 residents. There were 69 residents at the facility on the day of the audit.

This partial provisional audit was undertaken to establish the level of preparedness to transfer services to a new build with 81 dual purpose beds. This audit was conducted against the relevant Health and Disability Service Standards and the service contract with the district health board. All requirements relating to the partial provisional audit were met.

There were no areas requiring improvement at the last audit and none identified as requiring improvement at this audit.

Consumer rights

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Organisational management

Oceania Healthcare Limited is the governing body responsible for the services provided at The Bayview. A business plan documents the scope, direction, vision, mission and values of the facility.

The facility is managed by an appropriately qualified and experienced business and care manager and supported by a clinical manager who is responsible for the oversight of clinical service provision. The clinical manager is a registered nurse. The facility management team is supported by the regional clinical quality manager.

Oceania Healthcare Limited's human resource policies and procedures are implemented and newly recruited staff undertake orientation appropriate to their role. Practising certificates for staff who require them are validated annually and an annual training plan is implemented to ensure ongoing training and education for all staff members.

Service delivery staff, and resident/family interviews reported that there is adequate staff available Proposed rosters reflect the staffing requirements for the new facility.

Continuum of service delivery

The current medicine management system is managed safely and medications are administered by staff who are competent to do so. No changes will be required for the service as a result of the new treatment/medication rooms sighted.

The food service meets the nutritional needs of the residents with any special needs catered for. Food is safely managed. The chef interviewed and kitchen team are well prepared for transitioning to the new service. Action planning has occurred and processes are in place to ensure adequate resources and food will be on hand on a daily basis during this time.

Safe and appropriate environment

There has been a new build of 81 dual purpose beds since the last audit that is proposed to replace the 79 bed rest home and hospital beds in the current facility. There is a current building warrant of fitness for the current facility and a current certificate of public use for the new facility. A planned, preventative and reactive maintenance programme is in place that complies with legislative requirements.

The suites/studios in the new facility all have ensuite bathrooms. The rooms in the new facility are spacious enough to allow for resident cares and ease of movement. There are accessible and safe external areas with shade for residents and their families/visitors. There is a monitored call bell system for residents to summon help when needed. Call bells in the current facility are responded to promptly. Essential emergency and security systems are in place to ensure resident safety with six monthly trial evacuations are undertaken.

Policies and processes are in place and implemented for waste management, cleaning and laundry.

Restraint minimisation and safe practice

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Infection prevention and control

The infection prevention and control programme is led by an experienced and appropriately trained infection control nurse. The programme aims to prevent and manage infections. Staff demonstrated good principles and practice around infection prevention and control which is guided by relevant policies. Staff are supported with regular education. Infection prevention and control planning has been considered with the new facility design and build. All measures have been put in place to promote a safe environment for residents, staff and visitors. Pandemic resources are available in readiness should an infection control event occur.

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	15	0	0	0	0	0
Criteria	0	35	0	0	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.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Oceania Healthcare Limited (Oceania) has a documented vision, mission and values statement displayed in the main corridor of the current facility. These are to be displayed close to the entrance in the new facility and are communicated to residents, staff and family through information in booklets and in staff training. In addition to the overarching Oceania business plan, the facility has a business plan specific to The Bayview that includes the new facility development. The Bayview is part of the Oceania group with the executive management team providing support to the facility. Communication between the facility and executive management occurs monthly with the clinical and quality and regional operations managers providing support during the audit. The monthly management reports provide the executive management with progress against identified indicators. The facility is managed by a business and care manager (BCM) supported by a clinical manager (CM). The BCM has worked for Oceania for 10 years as a BCM and for the last 2 years at this facility. The BCM is a registered nurse (RN) with a current practising certificate. The clinical care at the facility is overseen by the CM, who is a RN and has been in this position for 3 months. HealthCERT and the DHB have been advised of this appointment. The CM has 9 months past experience in clinical management at another aged care facility. The management team is

		supported in their roles by the Oceania executive and regional teams and have completed induction and orientation appropriate to their respective roles. The facility is certified to provide rest home, and hospital level care and currently certified to provide care for up to 88 residents. At the time of the audit only 79 beds were available for use due to a reduction in the number of residents living in shared rooms. There were 69 beds occupied at the time of the audit. Occupancy included 36 residents requiring rest home level care and 33 requiring hospital level care. The facility has contracts with the district health board (DHB) for the provision of: respite care; long-term support chronic health conditions; and residential non aged care services for younger persons with disabilities (YPD). Included in the resident numbers there was one resident identified as being under the YPD agreement assessed as hospital level care. There were no residents under respite or long-term support chronic health conditions contracts. The new facility has two floors with two wings each. There are a mix of studio rooms and care suites which have a separate bedroom and lounge in each of the four wings. There are 30 studios and 10 care suites on the ground floor and 31 studios and 10 care suites on the first floor. In the current facility there are no ORAs and residents will not be required to purchase a room on transition to the new facility. The new facility's 81 beds have the capacity to be made available as occupational right agreements (ORA). A couple in the current facility at rest home level care have entered in to an ORA for the new facility. The Bayview has developed a plan to transition current residents into the new facility. The move in is scheduled to occur 3-6 December 2018, with 1/3 of residents to be moved on each of the 3 days.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During a temporary absence of the BCM, the CM is responsible for the day to day operation of the service and is supported by experienced RNs, the regional clinical and quality manager and the regional operations manager. In the absence of the CM, the BCM with the support and help of the regional clinical and quality manager, ensure continuity of clinical services.

Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resource management policies and procedures are implemented and meet the requirements of legislation. The skills and knowledge required for each position are documented in job descriptions. Staff files reviewed demonstrated that recruitment processes for all staff include: reference checks; police vetting; identification verification; position specific job description; and a signed employment agreement. Professional qualifications are validated and there are systems in place to ensure that annual practising certificates and practitioners' certificates are current. Current certificates were evidenced for all staff that require them. An orientation/induction programme is available that covers the essential components of the services provided. It requires new staff to demonstrate competency on, and/or understanding of, a number of specific functions and tasks, including health and safety and personal cares. Staff interviews and documentation confirmed support to complete orientation. The organisation has a documented role specific, mandatory annual education and training module that has recently been reviewed and updated. There are systems and processes in place to ensure that all staff complete their required mandatory training modules and competencies. There is evidence in staff files that ongoing education is provided. Interview with the nurse practitioner confirmed a process for advanced care planning is in place and is implemented to guide staff. The CM and seven other RNs have completed interRAI assessments training and competencies and one RN is in the process of training. In addition one newly recruited RN who has yet to commence work has completed interRAI training. Care staff complete annual competencies, for example: moving and handling; hoist use; hand washing; and infection control. Interviews and training records reviewed confirmed that all staff, including RNs undertake at least eight hours of relevant education and training hours per annum. An appraisal schedule is in place and all staff files reviewed for staff employed greater than one year, evidenced a current performance appraisal. The facility's staffing rationale informs recruitment processes to ensure that sufficient suitable staff are appointed and available to meet the needs of all residents including those with non-acute medical conditions.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The facility currently has 73 staff consisting of: a management team, 14 RNs, HCAs; a diversional therapist; activities assistants; and household staff. Household staff include: laundry assistants; cleaners; and kitchen staff; who provide services seven days a week. The organisation's staffing and skill mix policy and formula provide guidance to ensure safe staffing levels within the facility are sufficient to meet the needs of residents' acuity and the minimum requirements of the DHB contract. Rosters are formulated four weeks in advance and staffing levels are reviewed to accommodate anticipated workloads, identified numbers, and appropriate skill mix, or as required due to changes in the services provided and the number of residents. There are casual RNs, HCAs and household staff available to supplement rosters when needed to accommodate increases in workloads and the acuity of residents such as additional hospital level residents. Rosters sighted reflected adequate staffing levels to meet current resident acuity and bed occupancy. Observation of service delivery confirmed that residents' needs were being met in a timely manner. Resident interviews stated that current staffing is adequate to meet the residents' needs. Staff interviews confirmed that they have sufficient time to complete their scheduled tasks and resident cares. The CM or BCM are available on call after hours for advice on clinical matters. Additional staff have been recruited, or are in the recruitment process, for the new facility. Interviews and the proposed roster sighted for the new facility demonstrated that there will be an increase in RN availability from: 3 to 4 on the morning shift and from 2 to 4 on the afternoon shift, providing at least one RN on each wing on both floors on the morning and afternoon shifts and one RN on each floor each night shift. On each of the four wings there will be two HCAs on the morning and afternoon shifts and one at night on each floor. Activities and cleaning staff resource has also been increased for the new facility. There is a dedicated nurses' station in each of the two wings of the ground floor of the new facility and one centrally located on the first floor. Residents, including those with ORAs, will have access to 24 hour care staff. Interviews and a review of proposed rosters confirmed that staffing will be sufficient to cover the configuration of the new facility.

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.	FA	The medication management policy reviewed identifies all aspects of medicine management and ensures medicines are administered safely to comply with legislation, protocols, and guidelines. The organisational scope defined applies to all medications used in all Oceania Healthcare Facilities. A electronic system for medicine management is in place and the medication round observed on the day of the audit. The staff observed demonstrated knowledge and understanding of their roles and responsibilities related to each stage of medicine management. All RNs and 10 senior HCAs have completed annual medication competencies and records are maintained. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These arrangements will be continued when the residents and staff move to the new facility. An imprest medication system is in place for managing stock. All medications sighted were within current use by dates. Clinical pharmacist input is provided and a pharmacist audit was reviewed. Internal audits are completed six monthly and the electronic system audits are completed weekly and monthly. Reconciliation of medicines are completed when each resident is admitted, if transferred back from the DHB and regularly by the nurse practitioner interviewed. The nurse practitioner reported that reconciliation is completed at each resident and on review of documentation it was confirmed that three monthly reviews occur. Drugs are stored securely in accordance with requirements. The drug registers provided evidence of weekly stock checks and accurate entries. All medications are in locked cupboards. The medication trollies are stored safely when not in use. Provision is available in the two new treatment/medication rooms sighted for appropriate storage of all medications. There are two treatment/medication rooms one on each level with restrictive swipe care access. Medication fridges are temperature monitored and this will continue in the new facility. All individual medication records reviewed were current. All requirements for pro re nata (PRN) medicines were met. Comments were documented on effectiveness of the medicine administered by the staff member. An alert sticker was used on the residents' progress notes if a PRN medication was administered. All allergies and sensitivities are documented or nil known if needed to evidence this information was requested.

		There are four residents who self-administer medications at the time of audit. Processes are in place to ensure this is managed in a safe manner. Medications errors are reported to the clinical manager and recorded on an incident form. There is a process to be followed and this was verified.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by a qualified chef and kitchen team and is in line with recognised nutritional guidelines for older people. The food service operations policy and guidelines are currently available and implemented by staff. The menu plans reviewed follow four weekly summer and winter patterns and has been reviewed by a qualified dietitian. Any recommendations from the dietitian at the time of the review have been implemented. Systems are in place for all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service has an approved food safety plan signed which will expire in September 2019. Food temperatures are monitored and recorded as part of the plan. All staff working in the kitchen have completed safe food handling training. A nutritional assessment is undertaken for each resident on admission to the facility by the RN and a dietary profile developed. The personal food preferences, special diets and/or modified texture requirements are made known to the kitchen staff and accommodated in the daily menu plan. Special equipment to meet resident's nutritional needs is available. Evidence of resident satisfaction with meals is verified by resident interviews, meal evaluation forms sighted, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure assistance is available to residents as needed. The chef was interviewed and explained the proposed changes when the service moves to the new facility. There are three other qualified chefs to cover this service as well as the main chef. No care staff will work in the kitchen or be responsible for different aspects of the food service this will be completed by the kitchen staff. Meals will be directly served from the servery to the residents in the dining room located near the main kitchen. Care staff will be responsible for assisting the residents with their meals. The two new kitchens were sighted on the tour of the facility and meet the

		requirements of the standard. A manual temperature control system is currently in place. The chef explained an electronic system is planned to be implemented for the new facility. The food system is already transitioning to a computerised system with minimal hard copy records being available.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented policies and procedures for the management of waste and hazardous substances are in place. Policies and procedures specify safety requirements that comply with legislation, including the requirements for clear labelling and disposal and collecting of waste. The hazard register is available and current. Current material safety data posters are available and accessible to staff in the current facility and these will be displayed in relevant places in the new facility as confirmed at BCM interview. Staff receive training and education in safe and appropriate handling of waste and hazardous substances. Interviews and observations confirmed that there is sufficient personal protective clothing and equipment provided, such as aprons, gloves and masks, which is appropriate to the recognised risks. Protective clothing and equipment was observed to be used correctly in all high-risk areas.
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 is displayed in the entrance to the current facility and there is a certificate of public use for the new facility. Buildings, plant, and equipment comply with legislation. Interviews and observation confirmed there is equipment available to support residents including: wheel chairs; shower chairs; hoists; and sensor alarm mats. Equipment and invoices sighted confirmed that this includes sufficient new purchases equipment, such as: beds; dining room tables and chairs; and lounge chairs for the new facility. There is an implemented planned and reactive maintenance schedule. Staff enter maintenance requests in a book and these are responded to promptly and signed off. There is an annual test and tag programme and this is up to date, with checking and calibrating of clinical equipment annually and before use for new purchases.

		Staff interviews and facility inspection confirmed there is adequate equipment to support care, including care for the YPD resident with a disability. Personal equipment for the YPD is for this resident's use only. Access to the new facility meets the mobility and equipment needs of residents. There are ramps and rails to facilitate access for all residents with disabilities including YPD. There are paved courtyards, landscaping of lawns is in progress, and areas where outdoor tables, chairs and shade umbrellas will be provided. Outdoor areas will be able to be accessed freely by residents and their visitors.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All room have full ensuite facilities with a shower, toilet and a basin. All ensuites have: a pull cord situated between the toilet and shower that activates an emergency alert to summon assistance in an emergency; approved handrails; a call bell; room for manoeuvrability of resident and staff; wide doorways, and hand basins within reach to facilitate ease of mobility and independence. Toilets for visitors and staff are located centrally in close proximity to communal areas and have a system to indicate vacancy and provide disability access. Hot water temperatures are monitored monthly and were noted to be maintained within recommended temperature ranges. Documentation and interviews with the maintenance person confirmed that temperatures had been assayed for the new facility. Where temperatures had varied from the recommend range corrective action was taken and confirmed to be within recommended temperature ranges.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Care suites and studios viewed were noted to have sufficient space to allow residents to mobilise safely around their personal space and bed area, with mobility aids and assistance. Residents can have their own room or bedrooms in the care suites have sufficient room to accommodate two singe beds should a couple wish to share accommodation. There was sufficient space to accommodate furniture, equipment and staff as required. Rooms have an inbuilt overhead system to facilitate the use of hoists and staff training in the use of the overhead hoist has been scheduled for 29 and 31 October. Residents and their families are encouraged to personalise their rooms. Residents' rooms include: residents' personal furniture; possessions and memorabilia; is appropriate to the setting; and is arranged in a manner that enable residents to

		mobilise freely. Resident interviews confirmed that they would be able to take whatever personal possessions from their current rooms with them to the new facility. There are two elevators in close proximity to each wing, to facilitate access for residents and staff between the two floors. There are designated areas to store equipment such as: wheel chairs and walking frames safely.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Each floor of the new facility has a separate centrally located dining room, where residents can have their meals with other residents. There is sufficient space in each resident's studio/suite for a dining table, for a resident to have their meals in their own room if they wish. There is a large lounge on both floors, as well as a smaller second lounge on the upper floor. The two main lounge areas have seating and small tables and have been fitted with cupboards at one end that will be used for activities as required. There are sufficient quiet areas for residents and their visitors to access if they wish, including access to a private external patio from each resident room. There are areas where YPD can find privacy.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Laundering of all facility linen is no longer undertaken on-site and clean linen is supplied as required by an off-site contractor. There is at least one laundry assistant on duty each day, seven days a week, who undertakes the laundering and ironing of residents' personal clothing. There are processes in place for the daily collection and distribution of facility linen and residents' clothing. There is clear delineation and observation of clean and dirty areas in the current laundry. The new facility has a designated laundry in the basement with sufficient space to ensure clear delineation of clean and dirty areas and areas for ironing and linen storage. There are cleaners on duty each day, seven days a week and cleaning duties and procedures are clearly documented, to ensure correct cleaning processes occur. Cleaning products are dispensed from an in-line system according to the cleaning procedure. The new facility has designated locked cleaning cupboards for the safe and hygienic storage of cleaning equipment and chemicals. Chemical data posters

		and safety data sheets are available in the current facility and will be available in the new facility. All relevant staff have received training in the use of the products provided. The cleaner stores dispensed chemicals on a trolley when cleaning and observation confirmed that the trolley is with them at all times. The effectiveness of cleaning and laundry processes are monitored through the internal audit process. Resident interviews and observation noted the current facility to be clean and tidy. Interviews confirmed that the current cleaning systems and processes will be implemented in the new facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Staff files and training records demonstrate that orientation and the annual training programme includes emergency and disaster procedures and fire safety A New Zealand Fire Service approved fire evacuation plan was sighted for the newly built facility. There is a nominated fire warden for each shift. Five staff, including the health and safety representative and CM, have undertaken fire warden training specific to the new facility and will provide training to other relevant staff. An evacuation plan exercise with the fire department is scheduled for 5 November. Interviews and documentation confirmed that fire drills are conducted at least six monthly. The new facility has a monitored fire alarm and there are both smoke detector and sprinkler systems throughout the building and correct signage displayed. All RNs and the health and safety representative receive first aid training and there are at least two staff members on each shift with a current first aid certificate. There are supplies to sustain staff and residents in an emergency situation including alternative energy and utility sources that are available in the event of the main supplies failing. These include: a port for an externally sourced generator; battery operated lighting; food, water, and continence supplies. All required emergency equipment and supplies were sighted on the day of audit and had been checked within required timeframes. Emergency equipment and supplies will be relocated to the new facility. The service's emergency plan includes considerations of all levels of resident need including those of YPD. There are call bells to summon assistance in all residents' rooms and toilets. The studios sighted had call bells in the bedroom and bathroom. In addition care suites had a call bell in the lounge dining area close to where the seating area was

		proposed. In the new facility staff will be altered to a call bell being activate via a pager, rather than buzzers which are used in the current facility, to reduce noise. Call bells are checked monthly by the maintenance person. Observation on the day of the audit and resident interviews confirmed that staff respond to call bells promptly. Call bell response times are monitored and there are systems in place to immediately escalate to senior staff if there are delays in call bell response. There are security systems in place to ensure the protection and safety of residents, visitors and staff. These include visitors signing in and out, automatic locking of the facility at 7pm, an intercom for after-hours access and night time security lighting. The new facility has monitored security cameras at all critical points in the corridors and external doors and RNs are alerted to the opening of emergency doors via their pagers.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas in the new facility have safe ventilation and external windows and sky lights that provide natural light. The new facility will be heated throughout by heat pumps. There is heat pumps in each studio and care suite. The environment in all areas of both the current and new facility were noted to be maintained at a satisfactory temperature on the days of audit. There are systems in place to obtain feedback on the comfort and temperature of the environment. Resident interviews confirmed that their environment was maintained at a comfortable temperature and there were no issues identified with the temperature of the facility. An area has been identified in the new facility that will be designated as an external smoking area for those residents who smoke.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	The service provides a managed environment that minimises the risk of infection to residents, staff and visitors to this facility by the implementation of an appropriate infection prevention and control programme. Infection control management is guided by the infection control manual developed at organisational level. The infection control programme and manual are reviewed annually. The infection control nurse (ICN) has completed relevant training for this role and the responsibilities are clearly outlined in a position description and signed and dated. The ICN is supported by the infection prevention and control committee

		which includes kitchen, laundry and care staff. The ICN reports directly to the CM and the BCM. Infection prevention and control meetings are held monthly and minutes of meetings were reviewed. Infection control matters, inclusive of surveillance results, are reported monthly to the CM and tabled at the quality and risk meetings. Staff interviewed were informed and understood how long they must stay away from work if they are unwell and when to return to work. The ICN confirmed availability of resources to support the programme and any outbreak of infection. There have been no infection outbreaks since the last audit. A tour of the new facility and interviews with the project manager and the organisations senior management team evidenced input had been sought for the new building as required from an infection control perspective. There are adequate hand washing facilities located and positioned in all areas of service delivery. All flooring, equipment, furniture sighted is made from materials suitable for cleaning to maintain infection control principles.

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.

No data to display

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.