

Henrikwest Management Limited - Catherine Lodge Retirement Home

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](#).

The specifics of this audit included:

Legal entity: Henrikwest Management Limited

Premises audited: Catherine Lodge Retirement Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 13 March 2019 End date: 13 March 2019

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: 31



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Catherine Lodge Retirement Home provides rest home level care for up to 35 residents. The service is privately owned and is one of three facilities owned and operated by Henrikwest Management Limited. All services are overseen by the general manager, with day to day service operations managed by the facility manager who is an enrolled nurse with a current practising certificate. The regional manager oversees non-clinical aspects of the service across two sites but is based at Catherine Lodge. The management team is supported by a registered nurse. 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, management, staff, and one owner/director. The general practitioner was not available for interview at the time of audit.

This audit identified one area related to service provider availability that requires improvement. There were no areas for improvement to be followed up from 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.
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Residents and family reported that they are given sufficient information and feel informed. Information regarding the services is provided and resident satisfaction surveys are conducted. Records of family contact are maintained and there was evidence that family are notified as 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.
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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the owner/directors 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, orientation 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 regular individual performance review. 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.		Standards applicable to this service fully attained.
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Residents receive appropriate services that meet their desired goals/outcomes. InterRAI assessments and care plans are developed as required with interventions sufficiently detailed. Timeframes for service delivery are met.

Planned activities are appropriate to the needs, age and culture of the residents.

A hardcopy medicine record management system is in place to ensure safe delivery of medications to the residents. All staff administering medications have completed a medication competency. There is protocol in place for the residents who self-administer medications.

Food services meet the food safety guidelines and are reviewed by a dietitian every two years. The service has a food control plan in place. The individual food, fluids and nutritional needs of the residents are met. Interventions are in place when weight changes are identified.

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.
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There is a current building warrant of fitness.

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. At the time of audit, the facility was restraint free. A comprehensive assessment, approval and monitoring process is described in policy and understood by management and staff. Policy states the use of enablers is voluntary for the safety of residents in response to individual requests.

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.
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Infection control surveillance activities are appropriate to the size and scope of the service.

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	1	0	0	0
Criteria	0	38	0	1	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns 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.</p> <p>The complaints register reviewed showed that 35 complaints and concerns have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Actions taken related to complaints and concerns identified that information is used to make improvements to the service where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>A Health and Disability Commission complaint (HDC) was opened in January 2017 and closed in June 2018 with no further action required. The HDC acknowledged that adequate information had been given. When responding to this complaint the service had documented evidence that an anonymised version of the complaint had been presented at a staff meeting related to the importance of wound care management, including accurate documentation of dressing procedures. A three-month audit of a sample of injury/wound management charts were provided to the district health board to show that wounds were being appropriately managed. Wound care management charts sighted on the day of audit were appropriately documented and good practice wound care management procedures were sighted.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents interviewed said communication with staff was open and effective, which was confirmed by observing staff and resident interactions throughout the day. Staff are easily identifiable by their uniform and name badge. Residents said they were being reliably informed about any untoward event or changes to their care. Catherine Lodge Retirement Home has an open disclosure policy which clearly described the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the annual education programme. Staff interviewed confirmed their understanding of open disclosure. Communication with relatives is documented in residents' records. The sample of incident forms reviewed contained evidence that families and/or other interested parties were informed about an event.</p> <p>The facility manager confirmed that an interpreter services policy is available and that translators or other forms of communication would be offered to residents who use English as a second language.</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>The strategic, quality and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly and annual reports to the owner/directors showed adequate information to monitor performance is reported including all quality data such as infection control, health and safety, quality reviews, audits, financial performance, emerging risks and issues.</p> <p>The overall service is managed by a general manager who has been in the role for over six years. The day to day management of the service is undertaken by the facility manager who is an enrolled nurse with a current practising certificate. She has been in the role for over 19 years. The third member of the management team, the regional manager, oversees non clinical areas such as ordering of supplies. She has been in this role for over four years. The supply manager works across two facilities and is based at Catherine Lodge, the general manager covers all three facilities owned by the group. The management team is supported by a full time registered nurse. All members of the management team hold relevant qualifications. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The general manager and facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintain currency through ongoing education related to their roles. Education attendance records sighted covered both clinical and management topics and included attendance at Waitemata District Health Board (WDHB) seminars, age care related education and group sector meetings.</p> <p>The service holds contracts with the Auckland DHB for rest home level care related to mental health long term services, chronic health long term services, and age related care which includes respite care. Thirty residents were receiving services under the Age Related Residential Care contract and one resident was receiving services under an individual Mental Health Residential Support- Long Term Services – Young Person with Disability Contract at the time of audit. No residents receiving services under the Long Term Service – Chronic Health Contract at the time of audit. On the day of audit, 33 beds were occupied being 31 rest home level care residents and two boarders who</p>

		are not included in this audit as they only receive accommodation, meals and cleaning services.
<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>	FA	<p>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, a regular resident and family satisfaction survey, monitoring of outcomes, clinical incidents including infections, wounds, pressure areas and falls. All quality data and business planning processes are available to management staff on a shared electronic file which can be accessed at any time.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly management and staff meetings. Issues such as infection control and concerns or complaints are also discussed at the two monthly resident meetings as appropriate. All meeting minutes are detailed and identify that outcomes of items raised are reported back at each meeting. An annual management report related to all quality data groups clearly identifies and benchmarks against previously collected data to indicate if the service has improved or declined in each of the reported areas and actions taken to maintain quality standards.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities and implementation and evaluation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey conducted in June 2018 showed that all but three criteria of service delivery gained a satisfied or very satisfied result. The three issues identified as requiring improvement (knock on resident doors before entering, staff to use a more respectful telephone manner and more activity outings), have all been documented showing corrective actions taken and outcomes measured. For example, all issues were addressed at staff meetings and appropriate education was put in place such as consumer rights education. Residents were asked at their meetings if services had improved in these areas and family are asked if they have any concerns when they visit. No negative comments were made by staff or family during the audit.</p> <p>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.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. A hazard analysis is documented monthly and includes all relevant incident and accident information. Management are familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The service has a nominated health and safety champion.</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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Family are informed of all incidents and accidents related to their relatives. Adverse event data is collated, analysed and reported to all members of the management group, the owner/directors and staff.</p> <p>The general manager and facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. There have been no police investigations, coroner's inquests, issues-based audits and any other notifications since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>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 being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period with annual staff appraisals undertaken. All staff files reviewed showed that performance reviews and annual appraisals are up to date.</p> <p>Continuing education is planned on a biannual basis, including mandatory training requirements. Ongoing education and training is undertaken both on-site and off-site. On-site presentation of training is undertaken by management, the registered nurse and guest speakers. This was confirmed during staff and management interviews and in staff training records sighted. 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. There is one registered nurse who is trained and competent to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual competency requirements to undertake interRAI assessments.</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>PA Low</p>	<p>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). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. An extra shift is shown on the roster for a staff member to work 8am to 10.30am when the workload increases. Staff confirmed this duty is filled whenever required.</p> <p>Rosters identified that staff cover has been provided, with staff replaced in any unplanned absence. All shifts are covered by staff who hold a current first aid certificate. Registered nursing cover is provided Monday to Friday for eight hours and on call.</p> <p>Cleaning is provided for 5.5 hours per day, seven days a week. Kitchen staff work from 7am to 1.30pm, seven days a week with kitchen hands covering the evening meal from 4pm to 6.30pm.</p> <p>Laundry is undertaken by health care assistants and cleaning staff as part of their everyday duties.</p> <p>The general manager is available at all times. The regional manager works Monday to Friday from 9am to 5pm and visits a sister site one day a week. The facility manager works eight-hour shifts, Monday to Friday and is on call.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is clearly documented to guide staff and identifies all aspects of medicine management.</p> <p>A safe system for medicine management was observed on the day of audit, using a manual system. The staff member/team leader observed administering medications demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Competencies were sighted in the individual staff records reviewed. The registered nurse verified that annual competencies are completed.</p> <p>There were no controlled drugs onsite at this rest home.</p> <p>All medication is stored in a locked cupboard and the locked medication trolley is locked away when not in use. The records of temperature for the medicine fridge reviewed have readings documenting temperatures within the recommended range.</p> <p>The GP's signature and date were recorded on the commencement and discontinuation of medicines. The three-monthly GP review was recorded on the medicine charts.</p> <p>There were seven residents who were self-administering topical creams/eye drops/nasal sprays at the time of audit. Documentation is in place to ensure this is managed in a safe manner.</p>

		<p>Medication errors are reported to the registered nurse and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>Standing orders are not used. Any pro re nata (PRN) (as required) medication administered requires authorisation on the resident's medication chart. All PRN medication administered, have documentation to verify the effectiveness of the medicine. PRN medication requests include indications for use. The registered nurse monitors PRN medication usage and reports this to the GP as needed.</p> <p>The contracted pharmacist prepares the blister packs and audits the medication system six monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food, fluid and nutritional requirements of the residents at Catherine Lodger Retirement Home are provided in line with recognised nutritional guidelines for older people as verified by the dietitian's documented assessment of the planned menus within the last two years. A food control plan was sighted which is due to expire 10 January 2020.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility by the registered nurse and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the chef and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complied with current legislation and guidelines. The chef is responsible for the purchasing of all food stuffs which are brought locally on a weekly basis or more often if needed.</p> <p>The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored and records were sighted. A cleaning schedule was sighted as was verification of compliance.</p> <p>Evidence of resident satisfaction with meals was verified by residents and family members interviewed. Satisfaction surveys and residents' meetings minutes also evidenced that the meals were enjoyed. The chef interviewed has worked at the facility for two years and stated that sometimes meals are cooked individually to meet the individual needs of residents.</p> <p>There are enough staff on duty in the dining room at meal times to ensure appropriate assistance is available to residents as needed. The large dining room is set up to accommodate the residents in this home. Most of the residents eat their meals in the dining room but can have them in their room if they request this.</p> <p>The main meal at Catherine Lodge Retirement Home is served at lunchtime, with a lighter meal being served in the evening. Interviews verified this is in line with resident's needs.</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>FA</p>	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs and desired outcomes. Documentation was comprehensive and addressed all areas of care delivered. Interventions were updated in line with residents' changing needs. Potential side effects to new medications were documented with the alerts to be aware of. New or changes in medications or interventions are monitored for effectiveness.</p> <p>The GP was unable to be interviewed. The registered nurse interviewed stated the staff are able to cope with residents presenting with challenging behaviours.</p> <p>Residents and a family member expressed a high level of satisfaction with the care provided.</p> <p>There were adequate supplies of resources and equipment available to meet the residents' needs.</p>
<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>	<p>FA</p>	<p>The activities programme at Catherine Lodge Retirement Home is provided by the diversional therapist (DT) and an activities coordinator. The DT appointment was made in January this year and is a newly implemented position. The activities coordinator interviewed has been in the role for one year. The activities coordinator is a qualified DT who has completed the New Zealand Society of Diversional Therapy registration requirements which was verified in the training records reviewed.</p> <p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activity programme that is meaningful to the residents. The planned monthly activities programme sighted matched the skills, likes, dislikes and interests evidenced in assessment data. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Attendance is recorded and activities assessments and activities plans are signed off by the DT who oversees the programme. The activities coordinator and DT attend regional meetings and find this networking experience with other activities staff as being valuable. The residents enjoy the van rides in the community and/or to appointments if arranged at the DHB outpatient clinics.</p> <p>Entertainment is provided on a regular basis as most of the residents enjoy music sessions. The location enables some residents to walk to the local shops with a staff member. Family/whānau and friends are welcome to visit anytime and attend activities if they wish. Group activities are developed according to the needs and preferences of the residents who choose to participate. Residents were observed enjoying the group activity of the day with morning and afternoon sessions being available. Other activities documented on the activities plan reviewed included quizzes, movies, bingo (with prizes) bowling and other activities. Activities provided were meaningful to the individual residents interviewed. One on one activities are also provided as required. The Catherine Lodge newsletter is produced monthly and highlights activities and up and coming events for both residents and family/whānau.</p> <p>A residents' meeting is held six monthly. Meeting minutes, and satisfaction surveys evidenced the activities</p>

		programme is discussed and that management are responsive to requests. Interviews verified feedback is sought and residents are satisfied with the activities offered.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	Resident care evaluations occur six monthly in conjunction with the six monthly interRAI reassessment or as the residents' needs change. Where progress is different from that expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted, for example, urinary infections, skin tears, wounds, weight monitoring and blood sugar levels if needed to be performed. When necessary and for unsolved issues/problems, the long term care plan is updated. Residents and family members interviewed provided examples of their involvement with assessment of progress and any resulting changes. The family/whanau communication record is completed should the staff make contact with family/whanau.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	A current building warrant of fitness (expiry date 28 September 2019) is publicly displayed. All paper work is maintained to show compliance requirements are regularly maintained. There has been no change in the building footprint since the previous audit.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>In line with the infection prevention and control policy and procedures, monthly surveillance is occurring. Data is collated each month and analysed by the registered nurse to identify any significant trends or possible causative factors. Incidents of infections are presented at the quality and staff meeting held every month and any necessary corrective actions are discussed, as evidenced by meeting records, IC records and staff interviews. Any immediate action required is presented to staff at hand over. Incidents of infections are graphed and on display in the staff room. A comparison of previous infection rates is used to analyse the effectiveness of the programme and evidences a marked reduction in infections and antibiotic use. The surveillance programme is appropriate for the size and nature of this service.</p> <p>There have been no outbreaks of infection since the last audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 (facility manager) provides support, education and oversight for safe enabler and restraint management. She demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, no restraints or enablers were in use. Policy states that enablers will be the least restrictive and used voluntarily at the resident's request.</p> <p>The restraint coordinator and policy confirmed that restraint would only be used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, staff meeting minutes, observation and staff interviews. Challenging behaviour charts are put in place as required which identify alternatives to restraint. Staff confirmed their understanding of behaviour management during interview. Documentation identifies that medical staff, families, the resident and clinical staff are informed if a challenging behaviour chart is put in place.</p>
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>There is a documented process which determines service provider levels and skill mixes in order to provide safe service delivery. Observations and review of four weeks rosters identified that there was one hour, from 11pm to 12 midnight where only one staff member was on duty. This does not meet the minimum staffing requirements for rest home level care and was discussed with management. They confirmed the occupancy had only gone over 30 in the month of March 2019. The roster was changed at the time of audit and the second afternoon staff member's hours were increased to cover the one-hour deficit. Amended rosters were sighted and confirmed by the facility manager and the general manager.</p>	<p>The rosters reviewed identified that from 11pm to 12 midnight only one staff member was on duty.</p>	<p>Provide evidence that staffing levels and skill mix meet the documented process for ensuring safe service delivery levels are maintained at all times.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.