Shona McFarlane Retirement Village Limited - Shona McFarlane Retirement Village

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Shona McFarlane Retirement Village Limited
Premises audited:	Shona McFarlane 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: 12 February 2020 End date: 13 February 2020
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:	79

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
	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

Shona McFarlane is part of the Ryman group providing care for up to 79 residents in the care centre and up to 20 residents at rest home level in serviced apartments. On the day of audit, there were 77 residents in the care centre and two residents in the serviced apartments.

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

The village manager has been in the current role for one and a half years. She is supported by an assistant manager and an acting clinical manager. The management team is supported by the Ryman management team including regional manager.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services.

There were no shortfalls identified at the previous audit.

There were two areas for improvement identified at this audit around care plan interventions and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code). Residents and family interviewed verified ongoing involvement with the community.

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.		Standards applicable to this service fully attained.

There is a business plan with goals for the service that has been regularly reviewed. Ryman Shona McFarlane has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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.

Registered nurses are responsible for initial assessments, risk assessments, development of care plans in consultation with the resident/relatives. Care plans demonstrate service integration, are individualised and evaluated six-monthly. The general practitioner reviews residents at least three monthly.

The activity team implement the Engage activity programme in the rest home and hospital wings that ensures the abilities and recreational needs of the residents is varied, interesting and involves volunteers, entertainers, outings and community visitors.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. There are three-monthly GP medication reviews.

Meals are prepared on site. The project delicious menu is designed by a dietitian at organisational level and provides meal options including gluten free and vegetarian. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the food that was provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

The building has a current warrant of fitness. There is a preventative and planned maintenance schedule in place.

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.

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were two residents using restraints and one resident with two enablers during the audit.

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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. The service engages in benchmarking with other Ryman facilities. Staff receive ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	0	0	0
Criteria	0	39	0	2	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 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are available and located in a visible location. Information about complaints is provided on admission. Interviews with all residents and family confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. There were seven complaints logged for 2019 and included both verbal and written complaints. Two complaints for 2019 remain open (from December 2019). Both are being followed up at regional manager level, family communication has been documented during this process. There is also a health and disability complaint in progress from 2019. This also remains open as the commissioner has not yet completed their investigation. The service has raised a quality improvement plan (QIP) around the complaint and has undertaken an internal investigation. All actions in the QIP have been completed (staff training as an example). The QIP remains open until the commissioner closes the complaint. Five complaints year to date for 2020 have been logged and all have been completed and closed.
Standard 1.1.9:	FA	There is a policy to guide staff on the process around open disclosure. The village manager, acting clinical

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		manager, and two RNs interviewed, confirmed family are kept informed. Relatives interviewed (two hospital and one rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that is not covered by the agreement. The information pack is available in large print and in other languages. Access to interpreter services is available if needed for residents who are unable to speak or understand English. Family and staff are used in the first instance.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Shona McFarlane Retirement Village is a Ryman Healthcare facility. The service provides care for up to 79 residents in the care centre at hospital and rest home level of care. All 79 beds are dual-purpose. There are also 20 serviced apartments certified to provide rest home level of care. There were two rest home residents in the serviced apartments at the time of the audit. On the day of audit, there were 77 residents in the care centre; 37 hospital level residents including one funded through a chronic medical illness contract and three hospital level care residents on respite care (one funded by ACC). There were 40 rest home residents, including two rest home residents on respite care (one was a Ryman 48-hour respite person). All other long-term residents were under the aged related residential care (ARRC) agreement. Ryman Healthcare has an organisational total quality management plan and a policy outlining the purpose, values and goals. Annual objectives are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives. Staff are kept informed of progress in the full facility meetings. The village manager (non-clinical) has been in this role for a year and a half. She is supported by an experienced regional manager who works closely with the manager though face to face meetings, skype, emails and phone calls. The service is currently recruiting for a clinical manager; at the time of audit an experienced Ryman clinical manager was supporting the service along with another clinical manager. The manager is also supported by an assistant manager, a hospital unit coordinator, rest home acting unit coordinator (and experienced RN) and serviced apartments unit coordinator. The village manager and one acting clinical manager have attended a two-day Ryman conference and leadership programme in the last year (one clinical manager is new to Ryman).

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Ryman Shona McFarlane continues to implement the well-established quality and risk management system that is directed by Ryman Christchurch. Quality and risk performance are reported across the facility meetings and to the organisation's management team. Discussions with the management team and staff, and review of management and staff meeting minutes, demonstrated their involvement in quality and risk activities. Resident and relative meetings are held. Minutes are maintained with evidence of follow-up. Annual resident and relative surveys are completed with the last survey completed in February 2019, with improvements documented form the previous year around food services. Results are benchmarked against all Ryman facilities. The service has policies, procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes. The quality monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. The service develops quality improvement plans where internal processes such as incident, infection control internal audit document an adverse result. QIP are documented as followed up, reported to meeting and resolved QIPs have included falls minimisation and pressure injury management. Six monthly trend analysis documented around falls, infection control, pressure injury and behaviours that challenge document in-depth analysis and follow-up. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Clinical indicators are graphed and identify trends in the data. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. Interviews with staff confirmed their awareness of clinical indicator trends and strategies being implemented to improve residents' outcomes. Health and safety policies are implemented and monitored. One health and safety officer was interviewed. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings.
Standard 1.2.4: Adverse Event Reporting All adverse,	FA	There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow-up action required. A review of ten incident/accidents forms identified that all are fully completed and include follow-up by a RN. The adverse event process documents links to the service meetings and informal meetings. This provides the

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.		opportunity to review any incidents as they occur. Neurological observations are completed if there is a suspected injury to the head. The village manager was able to identify situations that would be reported to statutory authorities. A section 31 report was sighted for an unstageable pressure injury.
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	There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (one-unit coordinator, two staff RNs, one diversional therapist, and three caregivers) included an application form and reference checks, a signed contract, a job description relevant to the role the staff member is in and completed induction checklists. All files reviewed included annual performance appraisals with eight-week reviews completed for newly appointed staff. A register of RN practising certificates is maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration. The orientation programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. Staff training records are maintained. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Training is provided through a variety of forums including staff and service meetings, journal club, in-service training sessions and skype. Registered nurses are supported to maintain their professional competency. Journal club meetings are provided two-monthly. Three of eleven registered nurses have completed their interRAI training. There are implemented competencies for registered nurses and caregivers related to specialised procedures and/or treatment including medication competencies and insulin competencies.
Standard 1.2.8: Service Provider Availability Consumers receive	FA	Ryman policy supports the requirements of skill mix, staffing ratios and rostering. There is a RN and first aid trained member of staff on every shift. Caregiver's interviewed stated that management are supportive and approachable. Staff interviewed advised that there are sufficient staff on duty at all times. Interviews with residents and relatives confirmed that there are sufficient staff on duty. The village manager and acting clinical manager both work 40 hours per week. There are 20 serviced apartments certified to provide rest home level of care. There were two rest

timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		home level residents living in serviced apartments at the time of the audit. The facility has two units, the Sunflower rest home and the Tulip hospital unit. There is a full-time unit coordinator at the rest home and hospital units (acting). Staffing at Shona McFarlane is as follows; Sunflower and Tulip are staffed as one unit with staff allocated to groups of residents. The current occupancy on the day of audit was 39 at rest home level (two in the serviced apartments) and 40 at hospital level. The staffing was as follows; Three RNs in the morning for a full shift and one-half shift. This includes the unit coordinators. In the afternoon there are two RNs and one at night. Caregivers; the AM shift and the PM shift both include six caregivers for a full shift and six for a shorter shift. There are five caregivers on duty at night. Specific staffing for the service apartments included one staff member seven days a week with the care centre staff supporting resident's afterhours. There is also an additional fluid nurse on duty in the morning shift and one lounge carer on duty in the afternoon shift.
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	There are policies and procedures in place for safe medicine management that meet legislative requirements. All medications are stored safely in a central medication room for the rest home/hospital and serviced apartment residents. Registered nurses and senior caregiver's complete annual medication competencies and education. Registered nurses complete syringe driver training. Medication reconciliation of monthly blister packs is checked by an RN with the signature on the back of the blister pack. Any errors are fed back to the pharmacy. There is one rest home resident self-medicating with a self-medicating assessment in place. The medications are kept in a locked drawer in the resident's room. The medication fridge temperatures and medication room air temperatures are taken and recorded daily with both temperatures within an acceptable range. All eye drops were dated on opening. There is a bulk supply stock for hospital residents which is checked weekly for stock levels and expiry dates. The service uses an electronic medication system. Twelve medication charts were reviewed (six hospital and six rest home). All medication charts had photographs, allergies documented and had been reviewed at least three-monthly by the GP (for permanent residents). Records demonstrated that regular medications are administered as prescribed. 'As required' medications had the indication for use documented. The effectiveness of 'as required' medications was recorded in the electronic medication system, however there was no evidence of administration of 'as required' oxygen for one resident receiving oxygen.

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	All food and baking are prepared and cooked on site. The qualified head chef is supported by another chef on duty daily, a cook's assistant and morning and afternoon kitchen assistants on duty daily. Food services staff have been trained in food safety and chemical safety. Project "delicious" is a four weekly seasonal menu with three menu choices for the midday meal and two choices for the evening meal, including a vegetarian option. The seasonal menu has been designed in consultation with the dietitian at an organisational level. Resident dislikes are accommodated and cultural and religious values. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Gluten free diets and pureed meals are provided. Pure foods are used to increase the nutritional value for pureed meals and other foods groups identified such as soups. The meals are served from a bain marie in the kitchen to residents in the adjoining dining room. Meals are delivered in hot boxes and served by care staff in the hospital wing and serviced apartment dining room. The chef and assistant cook rotate through the areas to assist with serving meals. The service has a food control plan that has been verified and expires July 2020. Fridges, freezer and chiller temperatures, end cooked temperatures and cooling temperatures are taken and recorded daily. The chilled goods temperature is checked on delivery. Twice daily serving temperatures are taken and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Residents can provide feedback on the meals through resident meetings, resident survey and direct contact with the food services staff. Residents and relatives interviewed spoke positively about the choices and meals provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	Residents interviewed reported their needs were being met. The family members interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultant. The care plans did not reflect the resident's current health status. Required health monitoring interventions for individual residents are set on the RN or caregiver work log, however there were shortfalls around monitoring requirements. Wound assessments, treatment and evaluations were in place for 13 residents with wounds (eight rest home and five hospital level). Wound assessments and management plans are completed on myRyman. When wounds are due to be dressed, a task is automated on the RN daily schedule. Wound care documentation was complete for two hospital residents with community acquired pressure injuries (one stage one and one unstageable) and two rest home residents with facility stage two pressure injuries of the toes. A section 31 was sighted for the unstageable pressure injury. An RN is the wound champion and reviews all complex and non-healing wounds. There is access to a wound nurse specialist at the DHB as required. There are adequate pressure relieving resources available. Continence products are available and resident files included a three-day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist

		continence advice is available as needed and this could be described by the RNs interviewed. Monitoring forms are set up on the electronic work log and include blood pressure, weight, blood sugar levels, pain, behaviour, food and fluids and neurological observations.
Standard 1.3.7: Planned Activities 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.	FA	The service employs two qualified diversional therapists with one based in the rest home wing and the other in the hospital wing from Monday to Friday. An activity assistant is employed form 1 – 4 pm Monday to Thursday and focuses on one-on-one activities with residents who choose not to be involved or unable to participate in the activity programme. There is a lounge carer in the hospital for evening activities and one-on-one time with residents. A weekend activity person has been recently employed for the weekends across the rest home and hospital. The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including but not limited to; Triple A exercises, board games, news and views, poets corner, memory lane, gardening, baking, men's group, sensory activities including pet therapy, themed events and celebrations. Rest home residents in serviced apartments can attend either the serviced apartment or rest home/hospital programmes. Some activities are integrated for all residents including entertainment. A qualified music therapist visits weekly and spends time with a group of hospital residents with cognitive loss around music appreciation and music therapy. Community involvement includes entertainers, speakers, pre-school children, cultural groups, volunteers (town house residents and Age Concern) and regular church services. There are regular van outings and drives to places of interest and community events. A mobility taxi is hired for hospital level resident outings. Activity assessments are completed for residents on admission. The activity plan in the paper-based files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau (as appropriate) are involved in the development of the activity plan. Residents/relatives can feedback on the programme through the resident and relative meetings and satisfaction surveys.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Files reviewed identified that long-term care plans had been evaluated by registered nurses regularly and at least six-monthly. Written evaluations for long-term residents describe the resident's progress against the residents identified goals and any changes are updated on the care plan. A number of assessments (including interRAI) are completed in preparation for the six-monthly care plan review. There is also a multidisciplinary (MDT) review completed that includes the primary RN, caregivers, DT, physiotherapist, resident, relative and any other health professionals involved in the resident's care. Records of the MDT review were evident in the resident files reviewed. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members

		interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires 3 May 2020. The service has serviced apartments and the care centre on the ground floor and independent apartments on the first floor. A reactive maintenance and planned maintenance schedule is maintained. There is a 12-monthly planned maintenance schedule in place that includes the calibration of medical equipment, functional testing of electric beds and hoists and electrical testing. Hot water temperatures in resident areas are monitored three monthly as part of the environmental audit and are stable below 45 degrees Celsius. The facility has wide corridors with sufficient space for residents to mobilise using mobility aids. There is adequate storage and space in the rest home and hospital wings for safe manoeuvring of hoists within bedrooms and for hospital level lounge chairs in communal areas. Residents are able to access the outdoor gardens and courtyards safely from both wings. Seating and shade are provided. Staff interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the on-line resident files. Infections are included on an electronic register and the infection prevention officer completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility and are displayed on the staff noticeboard. The infection prevention and control programme links with the quality programme including internal audits. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. There was a gastro enteritis outbreak February 2019 which was well managed and appropriately reported.
Standard 2.1.1: Restraint minimisation Services demonstrate	FA	Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. On the day of audit, there were two residents using restraints (bedrails and lap belt) and one resident using a bedrail enabler. The resident file for the resident using restraint (bed rail and lap belt) reflects a restraint/enabler assessment and consent. Staff training has been provided around restraint minimisation and

that the use of restraint is actively minimised.		enablers, falls prevention, and the management of challenging behaviours.

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 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	The service uses an electronic medication system for the charting and administration of regular and ‘as required’ medications. Indications for use of ‘as required’ medications was prescribed on the medication charts. Eleven of 12 medication charts evidenced ‘as required’ medications had been administered as prescribed.	One resident was prescribed oxygen and this had been given as required, however there was no evidence of this being administered on the signing chart.	Ensure the administration of oxygen is signed as given when required. 30 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	Four of six care plans reflected all the resident’s current health status. Not all required monitoring requirements had been implemented. The risk is considered to be low as corrective actions were completed on the day of audit.	(i) One hospital resident under the Chronic Medical Illness contract did not have the use of oxygen included in the care plan.	(i) - (ii) Ensure care plans reflect the resident current health

			(ii) The falls risk assessment had not been reviewed post two falls and the falls prevention strategies in the care plan did not reflect the high falls risk (reviewed on the day of audit). (iii) Post falls intentional rounding had not been commenced for another hospital resident post falls. (iv) Repositioning was not consistently recorded for one hospital respite resident under ACC.	status. (iii) – (iv) Ensure monitoring is implemented as required. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.