# Glenbrae Resthome and Hospital Limited

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Glenbrae Resthome and Hospital Limited

**Premises audited:** Glenbrae Resthome and Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 3 November 2014 End date: 3 November 2014

**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:** 38

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Glenbrae Rest Home and Hospital (Glenbrae) offers care for up to 41 residents of either rest home or hospital level care. On the day of audit 22 hospital and 15 rest home level care beds are occupied. They also have approval from the Ministry of Health to offer rest home level care only for up to 17 residents in the attached serviced apartments. The service has not used any of the apartments for rest home care to date.

There were two areas identified for improvement in the previous verification audit. One related to the building warrant of fitness and this has been fully addressed. Remedial work is still to be completed related to the instillation of fire doors between the care facility and the apartment area. One new area has been identified for improvement relating to medicine management.

## Consumer rights

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

The service adheres to the principles of open disclosure and notifies residents and their families where necessary and appropriate, of any matters that may impact on them.

Complaints management is undertaken to meet policy requirements. There is an up to date complaints register sighted. The service does not have any open complaints at the time of audit.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The service has an up to date organisational business plan (January 2014) and quality policy and objectives which describes the purpose, values, scope, direction and goals of the organisation. The processes sighted ensure services are planned, co-ordinated and appropriate to the needs of residents. The service is overseen by the operations and quality manager (OQM) who reports directly to the owner who visits the site once a week and is available via telephone at any time.

The service has a quality and risk management system which is understood and implemented by staff. Quality data results, including any corrective actions that are required, are shared with staff and management. Corrective action planning is used to improve service delivery where appropriate.

Adverse events are documented and identify that family/whanau are notified as appropriate. Resident and family/whanau interviews confirm they are happy with the level of care and services provided.

Human resources management processes meet legislative requirements. Staff interviewed confirm they are fully supported by the organisation to maintain and improve their knowledge and skills through on-going education both onsite and offsite.

The service implements staffing levels and skill mixes that meet contractual requirements.

## Continuum of service delivery

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| 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 medium or high risk and/or unattained and of low risk. |

The residents receive timely and appropriate services in order to meet the assessed needs and desired outcome/goals of residents at the rest home or hospital level of care. Each stage of assessment, planning, provision and evaluation of care is undertaken by suitably qualified and/or experienced staff who are competent to perform the function. The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care.

The activities are planned to meet the needs and strengths of the residents. The activities are appropriate to the resident’s needs and culture.

Food, fluid, and nutritional needs of the residents are provided in line with recognised nutritional guidelines. The menu is reviewed by a dietitian as suitable for the older person living in a care facility. All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation and guidelines.

A safe medicine administration system is observed on the day of audit. Staff who are responsible for medicine management are assessed as competent to perform the role. There is an area requiring improvement to ensure that all medicines that are given are signed as being given on the medicine chart.

## Safe and appropriate environment

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

The service has a current building warrant of fitness which covers all required buildings which addresses the required improvement from the previous audit. Remedial work has not yet been completed related to fire doors between the rest home and apartment areas. This previous area requiring improvement remains open.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Policy identifies that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. Currently the service has one chair lap belt enabler and five restraints in use (four bedside rails and one chair lap belt). Staff undertake annual education related to restraint minimisation and can verbalise their knowledge and understanding of safe restraint management processes.

## Infection prevention and control

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| 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. |

Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. Where the infection rates are higher than expected the service implements a risk management plan to address any shortfalls identified.

## Summary of attainment

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

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| **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 | 1 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 1 | 1 | 0 | 0 |

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| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **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 | Glenbrae implements policy related to complaints management. The service has a complaints register in place which identifies all complaints made and shows the follow-up actions taken are used to improve services as appropriate. One example relates to a complaint made by a family/whanau to say they were not happy with all the care provided by some staff members. Corrective actions include ongoing staff education related to specific care provision, updated education on the Code of Health and Disability Services Consumers’ Rights (the Code) and manual handling. The development of an individualised education plan for staff involved, and monitoring of their service provision by a senior staff member is well documented. The complaint is now closed. Complaints are reported at staff and senior management meetings monthly as confirmed in meeting minutes sighted. At the time of audit there are no open complaints. The facility manager confirms all complaints have been successfully managed internally since the previous audit.Interviews with five residents and two family/whanau members confirm they are aware of and understand the complaints process.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service has procedures in place to ensure residents, and where appropriate family/whanau, have a right to full and frank information and open disclosure from service providers. The two family member interviews confirm they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure is documented on the accident/incident form and in the residents' progress notes (evidenced in five of five residents' files).Wherever necessary and reasonably practicable, interpreter services are provided as per the sighted interpreter policy. The care staff interviewed report that they are able to communicate effectively with all residents (including the one resident who does not have English as their first language).The Aged Related Residential Care (ARRC) contractual requirements with the District Health Board (DHB) are met.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation’s business plan identifies the purpose, values, direction and goals. It was last reviewed in January 2014 using a strengths, weakness, opportunities and threat analysis. This identifies the need for more rest home beds which the service can offer with their approved use of the attached 17 apartments. To date this area has not been used for any rest home residents. The quality objectives and goals align with business planning and the quality policy which is resident centred. The operations and quality manager (OQM) has been in her role for over two years. She has 25 years’ experience in the aged care industry. The job description identifies that the OQM has authorised management of the overall site with direct reporting to the owner on at least a weekly basis. The OQM maintains her skills and knowledge via involvement with Lakes District Heath Board (LDHB) as the older persons care representative on the service level alliance team, attendance of New Zealand Aged Care Association forums, and infectious outbreak management education. She is an authorised assessor for Health Ed Trust staff training and is an Aged Concern counsellor. Five residents and two family/whanau members confirm they are very happy with the availability of the OQM who they can contact at any time. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The current policies and procedures in use are maintained by an off-site company. The contracted company has a system in place which ensures all policies and procedures meet legislative and good practice requirements. The OQM ensures updates to policies and procedures are managed to ensure obsolete policies are removed and that staff are aware of any new policies or procedures put in place. This is confirmed by staff interviewed who stated they have access to all policies in the nurses’ station.Glenbrae implements quality and risk management systems that reflect the principles of continuous quality improvement. Clear links can be seen between the quality plan and the business plan. Quality and risk systems include regular ongoing audits to identify areas where corrective actions may be required. Interviews with all 12 staff from across all areas of service confirm they understand quality systems and implement corrective actions as required. This is supported in staff meeting minutes sighted and the results of planned audits which cover all aspects of service delivery. All corrective action follow up data sighted is appropriate and signed off when completed by the OQM. Key components of service delivery which include health and safety, incident and accidents, infection control, complaints management and quality improvements are linked to the quality management systems. Outcome data is shared with staff and management. The owner of the facility and the OQM meet at least weekly and a formal handover of information occurs. This includes exception reporting and corrective actions taken.Quality improvement data is collected, analysed and evaluated and used to identify opportunities for service improvement via corrective action planning. One example given by staff relates to falls management and the actions that have been put in place to identify falls times and areas via use of a 24 hour clock in an effort to reduce falls. This is an ongoing project and interim fall rates indicate a drop in resident falls. This information is being monitored by the quality committee. Quality improvement data is benchmarked against previously collected data. This information is shared with all staff who have input into the development of corrective action planning as confirmed during staff interviews. Actual and potential risks related to all operations of the business are identified, documented and communicated to residents, family/whanau and staff as appropriate. The service has an up to date hazard register which is accessible to staff. It details all known and potential hazards and what actions have been taken to isolate, minimise or eliminate the hazard. Specific hazard identification and control sheet forms are used to document findings. Hazards are reviewed monthly at the quality meeting. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The OQM verbalised her understanding of requirements of reporting to statutory and regulatory bodies. There is a specific form for statutory and regulatory reporting. One report has been made to the Ministry of Health under ‘section 31’ incident reporting related to a non-resident related incident. All information is documented including corrective actions taken, as sighted on the day of audit.All adverse or untoward events are recorded by the service on incident and accident forms. A review of the incident forms in five residents’ files identifies that all incidents are reported to family/whanau as appropriate. This is confirmed during interviews with family/whanau members. The incident and accident forms identify if a corrective action is required. Meeting minutes identify that incidents and accidents and related data are discussed at staff and management meetings. Incident and accident data is benchmarked against previously collected data.  |
| 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 | Staff qualifications are validated prior to employment and on an ongoing basis. Annual practising certificates are sighted for 11 registered nurses (RNs), three enrolled nurses (ENs), 40 general practitioners (GPs), seven pharmacists and the pharmacy, one physiotherapist, one dietitian and one podiatrist. Processes are in place at organisational and facility level to ensure the appointment of appropriate service providers to safely meet the needs of residents. This is identified in job descriptions which clearly state each role’s scope of practice. A review of nine staff files identifies that good employment processes have been fully implemented and that staff files are current and well maintained. This includes evidence of orientation and induction processes, education attended, and annual appraisals being up to date. Staff education is discussed at each monthly meeting and during annual appraisals.Interviews with 12 staff from across the service confirm the orientation process ensures services can be delivered in a manner to meet all residents’ needs. One newly appointed caregiver stated her orientation process was appropriate to her role. Staff confirm orientation processes prepare staff in all areas to safely perform the role they are employed to do. The in-service education calendar and training content sighted identifies that staff are able to offer safe and effective care to residents. The OQM is an authorised Health Ed Trust assessor and actively encourages staff to complete recognised aged care ongoing education. Staff can access on-site and off-site education relevant to the area in which they work. All clinical staff and most non-clinical staff hold current first aid certificates. Resident and family/whanau interviews and the 2014 resident satisfaction survey returns sighted confirm staff deliver services in a manner that meet residents’ needs. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Glenbrae has documented policy in place that reflects the required staff skills mix to meet residents’ needs in a safe effective manner. A review of staff rosters identifies that staffing numbers and skill mix is maintained at a constant level and that staff are replaced for sick leave and annual leave. The service has a six week rotating roster in place. Each shift is covered by a RN and at least one staff member who holds a current first aid qualification. All staff report during interview that they have time to complete required tasks within rostered hours. If the resident acuity level is higher than normal staff confirm an additional staff member is rostered to meet the need. This is confirmed in the rosters sighted. A discussion was held related to staff leaving the facility to respond to emergency calls at the village located on the same site. The OQM is aware that there needs to be a minimum of two staff members on the floor at all times, one of whom must be a RN. Interviews with five residents and two family/whanau members confirm they are happy with standard of service provided. This is also confirmed in the 2014 resident satisfaction survey results.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Medicines for residents are received from the pharmacy in the robotic sachet delivery system. The sachets are checked for accuracy against the resident's medicine chart. A medicine reconciliation process occurs with new admissions and when the resident has been to a specialist or had a hospital admission. A safe system for medicine management was observed on the day of audit. Medicines are stored in locked medicine trolleys and in the locked room with the controlled drugs stored in a locked safe in the nurses office. There is a monthly stock rotation recorded for the medicines that are not packed in the sachets. The controlled drugs are stored in a locked safe, two staff sign the register at each administration and a weekly stock count is undertaken. The service's medicine fridge is monitored at least weekly and temperatures were within recommended guidelines. The 10 medicine charts reviewed have been reviewed by the GP in the last three months; this was recorded on the medicine charts. All prescriptions sighted contained the date, medicine name, dose and time of administration with any allergies highlighted in red ink. All medicine charts reviewed have each medicine individually prescribed. Five of the 10 signing sheets were fully completed on the administration of medicines; there is an improvement required at 1.13.12.1 to ensure all signing sheets are fully completed. There are documented competencies sighted for the staff designated as responsible for medicine management (12 RNs and three ENs). The RN reports that there are no residents assessed as competent to self-administer their medicines. The service has a self-administration competency for residents who are able to self-administer their medicines.The ARRC requirements are met.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The six week rotating menu, with seasonal variations, is approved by a registered dietitian in May 2013 as suitable for aged care residents. The menu review is based on the dietitian NZ audit tool for residents living in long term care. A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff to ensure all needs, wants, dislikes and special diets are catered for. For example, the service provides diabetic and texture modified diets to meet specific residents' needs. The care staff manage the additional food supplements for the residents (eg, Fortisip). Four of the five residents interviewed report they are satisfied to highly satisfied with the food and fluids provided. The remaining resident reports that even though the food is cooked well, they feel the overall quality of the food is not of a high standard (this resident has provided feedback to the staff regarding this). The satisfaction survey demonstrated positive feedback regarding the food. All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer are in their original packaging or labelled and dated if not in the original packaging. Staff have undertaken food safety management education appropriate to service delivery. The ARRC requirements are met.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | All five care plans reviewed (three hospital and two rest home), record interventions that are consistent with the residents' assessed needs and desired goals. Observations on the day of audit indicate residents are receiving care that is consistent with the residents' needs. The five residents and two family/whanau interviewed report that the service meets the needs of the residents. The file of the rest home resident reviewed using tracer methodology (tracer 1) records interventions for their specific medical condition and the hospital resident reviewed using tracer methodology (tracer 2) evidences changed interventions to meet the resident’s changed needs after an admission to the acute care hospital. The five residents and two family interviewed have high praise for the interventions at the service. The ARRC requirements are met. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities co-ordinator reports activities plans are individualised to the resident’s needs. The activities are developed in conjunction with the resident and where appropriate their family. The activities assessments and plans are documented in the diversional therapy plans, as sighted in the five residents' files reviewed. The diversional therapy plans reviewed are up to date and reflected individualised needs of the residents. The goals are updated and evaluated in each resident's file at least six monthly and with the annual multidisciplinary reviews. The activities coordinator reports where residents have a specific need, the service endeavours to provide the resources for this. The activities coordinator gave an example of a resident with an interest in memorabilia, and a trip to the local museum was organised for this resident. The activities assessment include social pursuits, intellectual interests, creative pursuits, physical activity, and outdoor interests. Where possible residents' independence is encouraged to maintain links with family and community groups. Residents are provided with outings on a routine basis. One to one activities are planned to meet the residents’ interests. Four of the five residents interviewed report they enjoy the range and variety of planned activities. The remaining resident interviewed reports that they choose not to participate in the planned programme and prefer to stay in their own room (the activities coordinator did report that there are one to one activities with the resident and they do participate in some of the group and rehabilitation therapies). The ARRC requirements are met. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The documented evaluations indicate the resident's progress in meeting goals, and care plans are updated to reflect progress towards meeting goals. The four of five care plans reviewed (three hospital and one rest home) evidence evaluations are recorded at least six monthly. The remaining rest home file records a seven month period for the last evaluation (this is a one off and not reflective of a systemic issue as an additional two files reviewed for evaluation of time frames show all are conducted within six months). The hospital resident reviewed using tracer methodology (tracer 2) has a two week period between evaluation to reflect changes to the resident’s condition. There are additional annual multidisciplinary reviews conducted which include input from the care staff, the GP, the resident, the family and the activities coordinator. Where progress is different from expected the service either updates the long term care plan or uses short term care plans for temporary changes. The five residents’ files reviewed indicate they are updated to reflect changing needs of the resident. The residents and family/whanau interviewed report involvement in the evaluation process and were satisfied with the care provided. The ARRC requirements are met. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Glenbrae has a current building warrant of fitness that expires on 24 February 2015. There have been no changes to the building footprint since the previous audit. The above area was identified for improvement in the previous audit and is now fully attained.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | Remedial work has yet to be completed to ensure all updated building code requirements are met related to the fire door between the rest home and apartment areas before the apartments are used for rest home level care. This was a previously identified required improvement. The risk rating has been reduced to low as the doors are on site but not yet installed and the service will not be using the apartments for rest home level care until this work is completed. This assurance was given by the owner and the OQM. The service has been in discussions related to this with their representative from LDHB who are aware of the situation.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Infection control data is collected on urinary tract infections, chest infections, wound infections, eye and ear infections and multi-resistant organisms. The surveillance data is gathered for rest home and hospital level of care residents. The monthly report of collected data is provided to senior management and presented at quality and staff meetings. The surveillance data collected is based on guidelines from an aged care consultant. Infection control data is included in the quality audit programme. All care staff members are responsible for the reporting of suspected infections to the infection control co-ordinator. The infection control co-ordinator is responsible for ensuring appropriate action, notification and follow-up is undertaken. The data sighted for October 2014 record that the number of infections has remained the same as the previous months. There was an increase in urinary tract infections and a decrease in skin and soft tissue infections. The analysis includes a summary of the findings and a corrective action plan to address the trends identified. With the increase of the urinary tract infections the summary identifies the resident’s frailty, with increased fluids encouraged and increasing assistance by staff to assist with the residents’ personal care. The residents have an additional fluid round in the afternoon. The action plans to reduce infections is discussed at staff meetings (as confirmed at interview with the care staff).  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Policy identifies the use of enablers is voluntary and that the least restrictive option is used to meet the needs of the resident. The service has five restraints (four bedside rails and one chair lap belt) and one enabler chair lap belt in place. This is confirmed in the restraint register sighted, during staff interviews, by observation and in staff meeting minutes. Interviews with the 12 staff identifies that staff fully understand safe restraint use and the difference between a restraint and an enabler.  |

# 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.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | Five of the 10 medicine signing sheets sighted have at least one administration time, where it is not recorded if the medicine was given or if the medicine was not given, the reason as to why. There is an improvement required to ensure all medicines given are signed as given, or the reason for withholding the medicine recorded on the signing sheet.  | Five of the 10 medicine signing sheets signed are not fully completed at each medicine administration. There is at least one time where the medicine signing section is blank, with no recording if the medicine was given or the reason for withholding the medication not recorded.  | Ensure all medicines given are recorded and signed as given on the medication signing sheet. 90 days |
| Criterion 1.4.7.1Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures. | PA Low | There are smoke stop doors in place between the main care facility and the apartment block which comply with current usage of the buildings. The finding related to the installation of new smoke stop doors to meet current building code regulations has not yet occurred. The doors have been purchased and a telephone discussion with the owner confirms they are waiting for the doors to be installed prior to using any of the apartments for rest home level care.  | The facility has purchased new smoke stop doors for the entrance between the main care facility and the attached apartment block. They have yet to be installed. | Smoke stop doors are installed to meet current building requirements prior to the use of the apartments for rest home level care.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.

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| No data to display |

End of the report.