

Bethesda Care 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](#).

The specifics of this audit included:

Legal entity:	Bethesda Care Limited
Premises audited:	Bethesda Care
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 21 October 2015 End date: 21 October 2015
Proposed changes to current services (if any):	Bethesda Care Limited is intending to provide 'medical' services for contracts such as palliative care, long term chronic illness, rehabilitation and pre-hospice respite for example. Consideration of this has been included in this surveillance audit.
Total beds occupied across all premises included in the audit on the first day of the audit:	70



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

Bethesda Care is a hospital and rest home owned and operated by the Seventh-Day Adventist Church. Bethesda Care is a not for profit organisation with 72 total beds in 68 rooms. All beds are swing beds, which means they can either be used for rest home or hospital level residents. The service is well designed for provision of medical services. The facility classifies itself as full occupancy at 70 residents as two double rooms used for couples are single occupancy.

The Chief Executive Officer oversees all services, including a village area, which is not part of the audit. Staff in the facility are not responsible for the care of residents in the village. The Director of Nursing (DON) is responsible for the overall co-ordination of care and allied health services and is supported by a Clinical Charge Nurse (CCN) who is a registered nurse.

There are no areas identified for improvement from this surveillance audit. The service meets the Aged Residential Care Agreement requirements and there is sufficient evidence to demonstrate that the service has the systems in place and competence to undertake medical services contracts such as palliative care, chronic illness, rehabilitation and pre-hospice respite for example. .

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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Staff communicate with residents and family/whanau members following any incident or complaint in a manner that is reflective of open and honest communication.

Staff, residents and family members are aware of the complaints process. Complaints are being investigated and addressed. A complaint and concerns register is being maintained.

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.
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The organisation's vision, values and mission are documented in the business Management and Quality and Risk Plans which are reviewed annually. The plans developed and implemented are used to ensure planning is co-ordinated and meets the needs of the residents. Bethesda incorporates the values and principles of the Eden Alternative which are well embedded into the service.

All required resident information is collected in an integrated record and stored in a safe place.

The quality and risk programme includes compliments, complaints management, incident reporting and policy and procedure review. Policies are current and available to staff. The Director of Nursing is responsible for document control processes. All new documents are signed by the chief executive officer. There is a risk management plan and hazards and risks are being identified, managed and reviewed. Internal audits and surveys are conducted. Where improvements are required following quality activities

this occurs in a planned manner. Essential notifications occur in a timely manner. Regular staff and resident meetings occur. The Director of Nursing reports monthly to the Board.

Staff recruitment processes are well implemented. All staff receive a comprehensive orientation/induction programme, ongoing education and annual appraisals. The Director of Nursing and two registered nurses are fully interRAI trained. The service implements safe staffing levels and appropriate skill mix to ensure the needs of residents are effectively met.

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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Services are provided by suitably qualified and trained staff to meet the needs of residents. Residents have an initial nursing assessment and care plan developed by one of the registered nurses (RN) on admission to the service. The service meets the contractual times frames for the development of the long term care plan. When there are changes in the resident's needs, a short term care plan is implemented to reflect these changes. The care plan evaluations are conducted at least six monthly on all aspects of the care plan.

Residents are reviewed by the general practitioner (GP) on admission to the service and at least three monthly, or more frequently to respond to any changing needs of the resident. The provision of services is provided to meet the individual needs of the residents. A team approach to care is provided ensuring continuity of services. Referrals to other health and disability services are planned and coordinated as required. The families interviewed reported that interventions were consistently implemented and that the service managed the residents in a manner suitable to their ongoing changing needs.

Evidence is seen of the facility being able to provide 'medical services' for contracts such as palliative care, chronic illness or rehabilitation. This includes training in the administration of intravenous (IV) medications, 24 hour pain pump management, and

advanced care plans. Allied staff are contracted to ensure physiotherapy and occupational needs are addressed as part of care planning. Evidence is seen of links with the community as part of discharge planning if required.

The service has a planned activities programme to meet the recreational needs of the residents with a focus on the Eden Philosophy of care. Residents are encouraged to maintain links with family and the community.

A safe medicine administration system was observed at the time of audit and all staff that administer medicines are trained in the use of a proprietary medication management system. The service has documented evidence that staff responsible for medicine management are assessed as competent to do so.

Residents' nutritional requirements are met by the service. Residents' likes, dislikes and special diets are catered for, with food available 24 hours a day. The service has a four week, summer/winter rotating menu which is approved by a registered dietician.

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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The facility has a current Building Warrant of Fitness (BWOFF). The BWOFF is displayed appropriately at the entrance of the facility.

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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Policies and procedures are in place should staff require them to implement safe restraint minimisation procedures. They identify that enablers are voluntary and the least restrictive option to allow residents to maintain independence, comfort and safety. Currently there are no enablers and one restraint in use. The use of restraint is monitored and communicated to staff, managers and family members with regular reviews and meetings.

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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There is a monthly surveillance programme, where infections are collated, analysed and trended with previous data. Where trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings and management quality meetings. Evidence is seen of education and staff involvement with any infections that are identified during the surveillance programme.

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	17	0	0	0	0	0
Criteria	0	39	0	0	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>There is a comprehensive complaints/concerns/suggestions/compliments policy and procedure which is clearly demonstrated in policy. All residents and, family/whanau/representatives receive a copy of the policy and procedure in the information pack on admission to this facility. The form utilised was readily available and a suggestion box was situated at reception.</p> <p>The director of nursing interviewed is responsible for complaints management for this service and any complaints are managed within appropriate timeframes as per right ten of the Code. All staff interviewed confirmed they understood and implemented the complaints processes to meet policy requirements.</p> <p>The complaints register is current and up-to-date. The complaints register is completed and reviewed monthly. The register is documented with each individual complaint having a code number, coded by type, source, date form received, description and managed by the (DON). Any (CEO) comments, actions and the date resolved are recorded accurately.</p> <p>All complaints have been signed off by the DON except for one complaint which remains open with the Health and Disability Commissioner (HDC). This complaint has been responded to by the DON in depth and copies of all comprehensive correspondence to the complainant and the HDC is able to be clearly verified. All documentation is well supported with personal records and training records. The register and all information about this complaint are easily able to be followed through as per the complaints procedure. Staff are updated at the staff meetings of any progress. The last correspondence received from the HDC office was August 2015.</p>

		<p>There have been no deaths referred to the Coroner but there are processes in place should this be required.</p> <p>Any outcomes or preventative actions taken are followed through and used as identified areas of improvement. The DON ensures the CEO is kept well informed.</p> <p>Residents have regular resident's' meetings to identify any issues or concerns as well as things they enjoy. Resident interviews confirmed that the meetings are successful and any concerns are followed up by management.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The key principles of open disclosure were described in policy. The registered nurses and the director of nursing interviewed understood about open disclosure and that residents have a right to full and frank information as required. The registered nurses have received training and this is documented in the training records and individual staff records reviewed. The service has an interpreter policy to guide staff and interpreter/translation services are readily accessible. An example of open disclosure was verified in the complaints management process, when the DON was managing a complaint with the Health and Disability Commission.</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>	FA	<p>The service has a specific manual documented and reviewed in 2015 which is accessible to all staff. The Leadership, Management and Quality and Risk Management Manual clearly describes all aspects of organisational management. The core purpose/vision, goals and values are clearly defined. The DON reports to the CEO who oversees all service delivery. The DON interviewed provides a quality management report monthly to the Board of Directors and is responsible for clinical management. The DON has a PhD in nursing and is very skilled in leadership, quality management and is an Eden alternative guide. The DON is a member of the Acquired Infectious Advisory Group and is involved in the aged care sector in varying roles inclusive of being on the Board of Directors for an aged care organisation with multiple sites throughout New Zealand.</p> <p>The DON is supported by a Clinical Charge Nurse (CCN) and the cultural/spiritual advisor, maintenance personal and an administrator.</p> <p>Job descriptions were available and sighted in the randomly selected staff records reviewed.</p> <p>The quality plan identifies the key principles and outlines the services vision and goals/objectives for 2015 to 2016. The quality plan is signed off by the CEO. The Eden Alternative is linked closely with the quality actions and projects undertaken to ensure services meet the resident's individual needs.</p> <p>All residents' agreements are signed and meet the obligations of the ARRC agreement.</p> <p>Residents/family/whanau/GP and staff interviewed stated positive comments about the overall management of</p>

		the facility.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>During the temporary absence of the DON, the (CCN) is able to oversee all clinical care and management and is supported by the other members of the management team and the registered nurses. The CEO and a representative of the Board are always available for advice and support if and when required. The CCN job description was sighted and outlines whom to report to and the responsibilities of this role.</p>
<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 Strategic, Risk, Business, Health and Safety Quality Plan 2015 - 2016 was reviewed. Clinical risk management processes are documented in the risk management plan which was sighted and is reviewed annually. The risk management policy clearly defines risk and clear definitions are used.</p> <p>Reports are collated from the risk analysis/event reporting forms completed by staff and are reported on a monthly basis. These include incident/adverse events/infection control, complaints, restraint minimisation and safe practice. The reports are reviewed by the quality team quarterly. Actual and potential risks identified are measured as to their consequence or impact and likelihood. A plan is developed by the DON to decrease or control consequences. Monitoring and auditing is used to monitor the impact and frequency of risks occurring. Various audits are undertaken as per the audit schedule such as personal records, cleaning, health and safety, pain management, audits, enabler review audit and falls audits.</p> <p>The DON has developed and implemented a comprehensive risk register. Action plans are evident and used to control or eliminate any risks to ensure the needs of the residents are effectively met.</p> <p>The service operates the principles of the Eden Alternative philosophy. The DON is a registered Eden Guide.</p> <p>Staff interviewed confirmed that they understood the quality and risk management programme and that they are involved in reporting, audits and undertaking corrective actions that are developed and implemented as needed. Staff have a good understanding of the Eden Alternative principles and that the focus on continuous improvements is a continuum. Feedback to staff is through the staff meetings held monthly. Minutes of meetings are maintained as well as copies of the reports presented to the Board on a monthly basis.</p> <p>Resident`s meetings are held and used as a discussion forum for any concerns. Residents interviewed confirmed that any issues are addressed by management.</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>Policies and procedures are in place which identify that all adverse events, unplanned and untoward events are recorded and followed up by the service providers. A comprehensive system is in place, one for incidents and one for adverse events. There are separate forms for residents and for staff. The forms sighted capture a significant amount of data inclusive of time of day, day of the week, body area affected, date, area code and action plan. This information is used to trend and benchmark against previously collated data. Any areas of improvement identified are actioned. Aetiology of events such as accidents/incidents are reported on to eliminate any possible reoccurrence.</p> <p>Staff are kept well informed of any findings and education sessions are arranged or presented at handover or at the staff meetings held monthly. This is supported in meeting minutes and management reports sighted.</p> <p>Staff interviewed reported that they understood the importance of documenting all incidents and accidents. The forms are clearly understood by staff. Family/whanau at interview confirmed that the DON and CCN are always available and they are kept up-to-date and informed of any incidents, accidents or concerns of family members. Documentation is evident on the incident/accident forms and on the family communication sheet in the front of each resident's individual record reviewed.</p> <p>There is an open disclosure policy to identify family/whanau/representative are informed. The DON and the GP interviewed are aware of the reporting requirements depending on the incident or event. All incident and accident reports are analysed and trended via the quality team.</p> <p>The GP, DON and CCN interviewed separately understood their statutory, regulatory obligations in relation to essential notification reporting.</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>The human resource management manual has been reviewed. Human resource management policies and procedures ensure good employment practices are undertaken and that all legislative requirements are met. A recruitment procedure is followed by management and a checklist is completed. The DON has a system to record all annual practising certificates for health professionals who require them is managed effectively and accurately annually. A copy of each annual practising certificate once verified is retained in each individual record. All staff have job descriptions and a copy was sighted in each respective staff record.</p> <p>All staff have completed orientation/induction at commencement of employment. Orientation checklists are completed in all staff records reviewed. Training records are maintained along with performance reviews and personal development education. Education is provided on an ongoing basis with mandatory training, updates and on-line choices to pursue further education are encouraged by the DON and the CCN. First aid is completed every two years by all staff. All health care assistants are working towards or have completed varying levels of competencies up to level four career pathways linked to the New Zealand Qualifications</p>

		<p>Authority (NZQA).</p> <p>Staff enjoy the opportunities for increased learning in relation to aged care. Interviews with residents/family/whanau confirmed they are pleased with all aspects of service delivery and that staff perform their roles in a professional and competent manner. Care and support is closely linked with the Eden Philosophy and residents/family/whanau appreciated the staff being trained appropriately to deliver services to a high standard.</p> <p>Medical Services: All 14 registered nurses inclusive of the DON are qualified and have received appropriate training to effectively manage Nikki pumps, enteral feeding and intravenous training. This is evident in the staff training records and individual staff records reviewed. All staff interviewed have experience in, for example, palliative care and managing residents with long term illness or pre-hospice respite.</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>	FA	<p>The service implements a documented process for ensuring staffing levels allow safe and efficient services to be delivered to residents to meet their identified needs. Rosters sighted identified that staff are replaced for annual leave or sick leave. All shifts are covered by a staff member who holds a current first aid certificate.</p> <p>During staff interviews, staff verbalised that they have sufficient time and staff to complete their required duties.</p> <p>Staffing retention is evident on the roster and during the interview process. The DON understands the staff skill mix required for this hospital, medical and rest home complex.</p> <p>Residents interviewed stated all their needs have been met in a timely manner.</p> <p>Medical Services: Registered nurses are all experienced and skilled to manage palliative care residents and all have attended relevant ongoing education. Education and training records are well maintained. The roster sighted reflects availability of staff and relevant staff mix required to meet medical service obligations and to meet the needs of all residents. There are adequate supplies, equipment and resources to meet the needs of residents requiring medical services for contracts such as palliative care, long term chronic illness, rehabilitation and/or pre-hospice care provision.</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</p>	FA	<p>The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, the process should an error occur as well as definitions for 'over the counter' medications that may be required by residents.</p> <p>The facility uses a proprietary medication administration system and evidence is seen of all staff being trained in the use of this process.</p> <p>Medicines for residents are received from the pharmacy in a pre-packed robotic delivery system. A safe system</p>

<p>and safe practice guidelines.</p>		<p>for medicine management was observed on the day of audit. Medicines are stored in locked medicine trolleys in the store room. Medicines that require refrigeration are stored in a sealed box in a separate area in a fridge in the kitchen.</p> <p>The medicine charts reviewed on the Medimap system were reviewed by the GP at last three monthly, with this review recorded on the medicine chart. All prescriptions sighted contain the date, medicine name, dose and time of administration. All medicine charts had each medicine individually prescribed. There was a specimen signature register maintained for all staff who administered medicines. All the medicine files reviewed have a photo of the resident on the Medimap medication system tablet to assist with the identification of the resident.</p> <p>There were documented competencies sighted for the staff (RN and healthcare assistants) designated as responsible for medicine management. The RN administering medicines at the time of audit demonstrated competency related to medicine management.</p> <p>Self-administration of medicines is not undertaken and the facility does not use standing orders.</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 kitchen and food handling policy states the food handling areas and practices will meet the requirements of the Food Act 1981. It includes guidelines for cleaning with a separate cleaning schedule, temperature requirements, hygiene standards for staff, purchasing of food, checking, storage and waste handling. Regular monitoring and surveillance of the food preparation and hygiene is carried out.</p> <p>The nutrition and food management is now managed on site. The menu is managed by the chef in consultation with a registered dietician and is a four week rotating menu with summer and winter variations. Where there is unintentional weight loss or weight gains, the resident is referred for a dietitian review; this is seen in the residents' files reviewed.</p> <p>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. There are food and nutritional snacks available 24 hours a day. The family and residents reported that they are satisfied with the food and fluid services.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings were observed daily and recorded at least weekly, with the recordings sighted meeting food safe requirements. The kitchen staff have undertaken food safety management education appropriate to service delivery.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>FA</p>	<p>As observed on the day of audit and from review of the care plans, support and care is flexible and individualised and focussed on the promotion of quality of life. The RN and healthcare assistants demonstrated</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>good knowledge and skills in the practices and through the management of challenging behaviour and redirection of residents who wander. The residents' files reviewed showed evidence of consultation and involvement of the family. The family reported that the service 'excels' at providing a supportive relationship with the resident that reduces anxiety and maintains a sense of trust, security and self-worth. The residents interviewed reported satisfaction with the care and services provided.</p> <p>The service had adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed record interventions that are consistent with assessed needs and desired goals. Observations on the day of audit indicated residents are receiving care that is consistent with their needs. The healthcare assistants interviewed reported that the care plans are accurate and up to date to reflect 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 weekly activities plan, which was sighted, was developed based on the resident's' needs, interests, skill and strengths. The healthcare assistants assist with the planned activities seven days a week, with the programme being developed by the senior activity coordinator. The programme is reviewed and evaluated at least six monthly.</p> <p>The programme is developed to reflect the Eden philosophy of making your home a habitat and flexibility with all timeframes as residents' needs change. All activity staff receive support and monthly meetings with a qualified diversional therapist. A qualified occupational therapist oversees activity staff monthly.</p> <p>The sighted activities programme covers cognitive, physical and social needs. The activities are modified to suit the individual needs and capabilities of each resident. There are group and individual activities that focus on sensory activities and reminiscing. The activity coordinators interviewed reported they try to utilise residents' interests and long term memories and assess the level of interest in activities as they are occurring and have the flexibility to change activities based on the resident's response.</p> <p>The service provides easy access to outside courtyard areas that enable the residents to wander safely. There are tactile objects and plants in the outside areas.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements.</p> <p>A daily activities attendance sheet is maintained and reviewed at the end of each month to assess the enjoyment and interest of the residents. The goals are updated and evaluated in each resident's file six monthly. The participation in activities is recorded on a daily basis. Where possible, residents' independence is encouraged to maintain links with family and community groups. Families are encouraged to attend activities. Families take their relative to religious services as appropriate and the service has a chaplain that visits.</p> <p>The families reported that their relatives enjoy the range and variety of planned activities.</p> <p>Medical: Residents admitted for dual service beds will be provided with social and recreational activities to meet</p>

		their needs. The activities co-ordinators interviewed are trained to provide one on one activities for rest home and hospital level residents.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>The residents' files reviewed had a documented evaluation that was conducted within the past six months covering all of the issues in the care plan. These evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the desired outcomes.</p> <p>If a resident was not responding to the services/interventions being delivered, or their health status change, then this is discussed with their GP. Residents' changing needs were clearly described in care plans reviewed. Short term care plans were sighted for wound care, pain, infections, change in mobility status, changes in food and fluid intake and skin care. These processes were clearly documented on the short term care plan, medical and nursing assessments and the resident's progress notes. The healthcare assistants interviewed demonstrated good knowledge of short term care plans and reported that these are identified at handover.</p> <p>The family reported that they can consult with the staff at any time if they have concerns or there are changes in the resident's condition.</p>
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current warrant of fitness due to expire 26 September 2016. The certificate is displayed appropriately in the entrance to the facility.
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	<p>The infection control surveillance that is undertaken is appropriate to the size and complexity for a hospital and rest home service as shown in the infection control programme. All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring was clearly described in the quality plan and management meetings, to describe actions taken to ensure residents' safety.</p> <p>The RNs are responsible for reporting infections to staff, management and family. They have had no specific outbreaks but on interview were able to verbalise the process they would take if this occurred. The GP reported by phone that he is satisfied with the staff regarding their knowledge and management of infection reporting.</p> <p>There is a monthly infection surveillance report. The service monitors urinary tract infections, eye infections, and upper and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea and</p>

		<p>vomiting and other infections. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease and actions taken to reduce infections. The analysis includes the feedback that is provided to staff.</p> <p>Staff interviewed understood the surveillance programme and were able to verbalise the action required for outbreak management or reporting of infections.</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>There are appropriate policies and procedures in place to guide staff actions related to restraint and enabler use. Policy states enablers are the use of equipment, devices or furniture, voluntarily used by the resident following appropriate assessment that limits normal freedom of movement, with the intent of promoting independence and safety. The use of enablers shall be voluntary and the least restrictive option to meet the needs of the resident.</p> <p>There was one restraint in use and no enablers in use at the time of the audit. The restraint was approved and implemented as a last resort after all other planned strategies for managing the resident safely had been utilised unsuccessfully. Interviews with clinical staff confirmed their knowledge and understanding related to restraint versus enablers and how they are managed. Staff interviewed are well informed and aware of the difference between an enabler and a restraint and what actions need to be taken related to the use of both.</p> <p>Training is provided annually and covers de-escalation techniques, such as calming, re-direction activities and understanding the individual needs of residents.</p>

Specific results for criterion where corrective actions are required

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

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

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

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.