

Malvina Major Retirement Village 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 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:	Malvina Major Retirement Village Limited
Premises audited:	Malvina Major 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: 15 February 2017 End date: 16 February 2017
Proposed changes to current services (if any):	
Total beds occupied across all premises included in the audit on the first day of the audit:	107

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

Ryman Malvina Major provides rest home, and hospital (geriatric and medical) level care for up to 120 residents in the care centre and up to an additional 20 residents in serviced apartments. On the day of the audit there were 107 residents. The service is managed by an experienced village manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant 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, staff and general practitioner.

The one shortfall from the previous audit around medication management has been addressed. This audit identified further areas requiring improvement around assessments and care planning for respite residents and documentation on incident forms.

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.	Green	Standards applicable to this service fully attained.
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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated and are appropriate to the needs of the residents. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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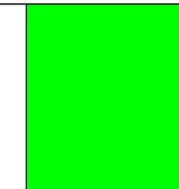
InterRAI assessments, risk assessments, care plans and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Resident and family interviewed confirmed they were involved in the care plan process and review and were informed of any changes in resident health status. The general practitioner completes an admission visit and reviews the residents at least three monthly.

The activity team provide an activities programme which is varied and interesting. The programme meets the abilities and recreational needs of the group of residents. Residents are encouraged to maintain links with community groups.

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. The general practitioner reviews medications three monthly.

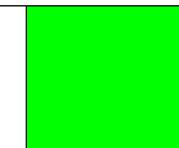
The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated. The reviewed menu plan offers meal choices.

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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A current building warrant of fitness is posted in a visible location.

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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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 six residents with restraint and one resident with an enabler at the time of the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

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 prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. A monthly infection control report is completed, trends identified and acted upon. Benchmarking occurs and a six-monthly comparative summary is completed. An outbreak in the hospital area in 2016 was well managed.

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	37	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available throughout the facility. Information about complaints is provided on admission. Interviews with all eight residents (five rest home including one in a serviced apartment and three hospital level) and family confirmed their understanding of the complaints process. Complainants are provided with information on how to access advocacy services through the HDC Advocacy Service if resolution is not to their satisfaction.</p> <p>Interviews with two managers (village manager and clinical manager) and staff (five care assistants – three from the hospital and two from the rest home, one who has previously worked for a long period in the serviced apartment area), two activities staff, the hospital and rest home coordinators (registered nurses) and serviced apartment coordinator (enrolled nurse) confirmed their understanding around the processes implemented for reporting and managing complaints.</p> <p>There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrated that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system.</p> <p>A complaint was made to the DHB and the auditors were asked to identify the steps Ryman took to minimise the disruption of the renovations and will take with the new round of renovation planned for 2017. It was also requested that rates of respiratory illness during the renovation period be assessed.</p> <p>The renovations started in the care centre in April 2016. All lounge/dining affected areas were sealed off with</p>

		<p>hoardings with scotia's to minimise noise and dust. A large temporary lounge including heating, furnishings and carpet was created in the atrium. The rest home moved back in to the renovated lounge/dining area in August 2016 and the hospital four weeks later. Following this the atrium was sealed off and work including re-tiling, occurred in the atrium. The fire doors to access the atrium were closed. During the entire period of the renovations, strategies to minimise the effect on residents (apart from the physical aspects noted above) included (but were not limited to): (i) Increased van driver hours for more outings to minimise distress; (ii) Utilisation other parts of village for activities – eg, the serviced apartment areas. (iii) Contractors were required to stop work during meal times. (iv) More external guests were contracted for additional entertainment. (v) Residents were invited/supported to use the serviced apartment lounge. (vi) There was financial compensation for residents closest to area that were paying a premium. (vii) Some residents moved at the organisation's cost into better rooms, further away with no extra cost (this move was permanent for these residents with no costs ongoing). No further renovations are planned for the care centre. The next building phase is in the serviced apartment area; all residents have been removed from the area/wing being renovated.</p> <p>There was no noted increase in respiratory rates during the renovation period. There was a small spike after the renovations were completed which was reflective of respiratory infection rates in the wider community.</p> <p>The DHB also requested a review of staffing levels following the complaint. Staffing levels have been reviewed following a reconfiguration of hospital and rest home residents being moved to specific floors. Staffing levels were satisfactory at the time of the audit (see 1.2.8 for further detail).</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>An open disclosure policy describes ways that information is provided to residents and families. 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 are not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p> <p>Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents' progress notes. All five family members interviewed (two rest home level and three hospital level) stated they were well-informed. Ten incident/accident forms and corresponding residents' files were reviewed (from across both service levels and including rest home level residents in serviced apartments) and all identified that either the next of kin were contacted or requested not to be contacted (minor events only). Regular resident/family meetings provide a forum for residents to discuss issues or concerns.</p> <p>Interpreter services are available if needed for residents who are unable to speak or understand English.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Malvina Major is part of a wider village. The service provides rest home and hospital (geriatric and medical) level care for up to 120 residents in the care area. Additionally, there are 20 certified serviced apartments.</p> <p>All rooms are designated dual-purpose. However recently, following feedback from residents and families, the service has moved to having all long-term rest home residents on the ground floor and all long-term hospital residents on the first floor. From time-to-time rest home level residents are cared for on the first floor if there are no beds in the designated rest home area.</p> <p>On the day of the audit, there were 51 rest home level residents in the 60 bed ground floor unit. This included three residents on respite – one private paying and two funded by the DHB. Additionally, there were two rest home level residents residing in the serviced apartments.</p> <p>On the 60 bed first floor unit, there were 54 hospital level residents. One was on a YPD respite contract, one on a private paying respite agreement and two on DHB funded respite contracts.</p> <p>All long-term residents were in the ARC contract. There were no residents under the medical aspect of the certification at the time of the audit.</p> <p>There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2017 are defined with evidence of monthly reviews for 2016 and quarterly reporting for 2016 to senior managers on progress towards meeting these objectives.</p> <p>The village manager has been in the position since May 2016. She is a registered nurse with a current practising certificate. She attended over eight hours (year to date) of professional development activities related to managing an aged care facility in 2016. The village manager is supported by a regional manager and a clinical manager/RN that has also been in the position since October 2016.</p> <p>The management team have each completed in excess of eight hours of training related to managing a hospital in the past year.</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</p>	<p>FA</p>	<p>Malvina Major has a well-established quality and risk management system that is directed by Ryman head office. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team (village manager and clinical manager) and staff, and review of management and Team Ryman meeting minutes demonstrate their involvement in quality and risk activities.</p> <p>Resident and family meetings are held monthly in the rest home and two to three monthly in the hospital. Minutes are maintained and issues are documented as addressed. Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed. The 2016 survey resulted in corrective actions around laundry services and the meal service.</p> <p>The service has policies, procedures and associated implementation systems to provide a good level of assurance</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>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.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are clear guidelines and templates for reporting. Management systems, policies and procedures are developed, implemented and regularly reviewed.</p> <p>The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the two-monthly health and safety meetings. A health and safety representative is appointed who has completed health and safety training. 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. The hazard identification resolution plan is sent to head office and identifies any new hazards. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified.</p> <p>Falls prevention strategies are in place. Lounge carers monitor residents in the lounges in an initiative to reduce falls.</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</p>	<p>PA Low</p>	<p>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.</p> <p>A review of ten recent incident/accident forms from across all areas of the service including the serviced apartments identified that all included follow-up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the applicable meetings (teamRyman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur. Not all electronic forms documented a description of the incident or follow-up.</p> <p>The village manager is able to identify situations that would be reported to statutory authorities. An appropriate section 31 notification was made around a pressure injury and an outbreak was notified to the appropriate departments.</p>

of choice in an open manner.		
<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>	FA	<p>There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (two care assistants, three registered nurses [including the clinical manager and one unit coordinator], one chef, one activities coordinator and one household staff member) provided evidence of signed contracts, job descriptions relevant to the role the staff member is in, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight week reviews completed for newly appointed staff.</p> <p>A register of RN and EN practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.</p> <p>An orientation/induction 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. The annual training programme exceeds eight hours annually. There is an attendance database for all evidence and an individual staff member record of training. Ryman Malvina Major offers an in-service training programme that includes all required areas over a two year period. An electronic database is kept and prior to the audit, the service had become aware that the electronic database was not recording all staff attendance at in-service sessions. A corrective action plan has been developed and commenced. All but two required areas of training had been repeated or records found by the time of the audit and the two trainings missing were planned to be repeated (each training is held several times to encourage attendance) in the month following the audit.</p> <p>Registered nurses are supported to maintain their professional competency. Staff training records are maintained. There are implemented competencies for RNs, ENs and care assistants related to specialised procedures or treatments including medication competencies and insulin competencies.</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>There are two registered nurse care coordinators (one in the rest home and one in the hospital unit). Both work 40 hours per week (day shift) and the clinical manager works 40 hours per week. These three staff have one weekend day off each to ensure there is always a manager on duty seven days per week. Additionally, there is a care coordinator in the serviced apartments who is an enrolled nurse and is overseen by the clinical manager. In the rest home (up to 60 rest home level residents) there is a registered nurse on duty on morning and afternoon shift and in the hospital there are three registered nurses on morning and afternoon shift and one overnight.</p> <p>The facility has undergone a recent staffing restructure in the rest home area (staffing in the hospital area has not changed). This occurred because the ground floor has 20 beds that were intended to be used for either rest home or hospital level residents, and the staffing on the ground floor was structured in an ongoing manner as if all these 20 beds were occupied by hospital level residents. In late 2016, following the decision to have the ground floor occupied solely by residents requiring rest home level care, staffing numbers were reviewed and reduced in this</p>

		<p>area to align with meeting the needs of only rest home level residents. This audit identified adequate staffing. The rosters sighted were completed to cover all shifts. Rest home residents observed had their morning ADLs met in a timely manner (observation by auditors, feedback from activity and domestic staff and residents). Management interviews and a review of call bell answering times monitoring identified adequate staff cover.</p> <p>There is a manager/registered nurse on call at all times.</p> <p>A registered physiotherapist is available 15 hours a week and a physiotherapy assistant carries out the rehabilitation programmes developed by the physiotherapist, also for 15 hours per week. There are separate laundry and cleaning staff.</p> <p>Residents interviewed stated that call bells were answered in a timely manner.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation of monthly blister packs is completed by RNs and signed on the blister pack. Any dispensing errors are fed back to pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for medication and insulin competency on an annual basis. Registered nurses complete syringe driver competencies. Care staff interviewed were able to describe their role in regard to medicine administration. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored weekly. The previous finding around medication fridge temperatures has been addressed. All eye drops and creams in medication trolleys were dated on opening. Expiry dates of all medications are checked weekly as per checklist. The previous finding around expiry dates has been addressed. There was one respite resident and one rest home resident in the serviced apartments self-administering medications. Self-medication assessments had been completed.</p> <p>The service uses an electronic medication system. Fourteen medication charts (eight hospital and six rest home) were reviewed on the electronic medication system. The effectiveness of 'as required' medications is entered into the electronic medication system. All medication charts had been reviewed by the GP at least three monthly. All administered medications corresponded with the medication charts. The previous finding around signing sheet gaps has been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	FA	<p>All food and baking is prepared and cooked on-site. The qualified head chef is supported by a second chef and kitchen assistants. There is an organisational four weekly seasonal menu that had been designed in consultation with the dietitian at an organisational level. Changes have been made to the menu plan to provide an increase in meal choice. There are three options for the midday meal and two options for dinner. A vegetarian option is available on the menu. Plated meals are delivered to the dining rooms in heated trolleys. The cook receives a</p>

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known and accommodated. Cultural, religious and food allergies are accommodated.</p> <p>The kitchen has been recently refurbished and all equipment replaced. Freezer and chiller temperatures and end cooked/serving temperatures are taken and recorded. All perishable foods and dry goods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing.</p> <p>Staff have been trained in food safety and chemical safety.</p> <p>Residents have the opportunity to provide feedback on the meals through resident meetings, survey and direct contact with the chefs. The improved menu choice has been in place six weeks and not yet formally evaluated.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Low</p>	<p>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. Long-term care plans are updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections. Respite care residents nursing care assessments did not reflect interventions to meet all current needs/supports.</p> <p>Wound assessments, treatment and evaluations were in place for wounds including skin tears, lesions, chronic wounds/ulcers and three stage-two facility acquired pressure injuries. Adequate dressing supplies were sighted in the treatment rooms. The service has a wound care champion/RN that reviews wounds and provides advice on wound care management. The RNs could describe access to the DHB wound nurse if required. Chronic wounds and pressure injuries are linked to the long-term care plans.</p> <p>Continence products are available and resident files include 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.</p> <p>Monitoring forms reviewed including food and fluid, weight, blood glucose and turning records indicated that interventions were occurring as required.</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</p>	<p>FA</p>	<p>There are three activity lifestyle coordinators employed to coordinate and implement the engage activities programme in the rest home and hospital. The hospital activity lifestyle coordinator is on duty Monday to Friday (33.5 hours) and there is an activity assistant for six hours Saturday and Sunday. The rest home activity programme is Monday to Friday. The hospital activity lifestyle coordinator has been involved in activities for the past year and the rest home activity lifestyle coordinator has been employed three weeks. The two-week vacancy was covered by a care assistant. The team attend on-site in-services relevant to their roles.</p> <p>The engage programme has set activities with the flexibility for each service level to add activities that are</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>meaningful and relevant for the resident group including Triple AAA exercises, themes events and celebrations, indoor bowls, sensory activities, outings and drives. Daily contact is made with residents who choose not to be involved in the activity programme. One-on-one time is allocated for hospital residents including hand massages. Community involvement includes entertainers, speakers and church services on-site in the chapel. Some activities are integrated such as serviced apartments and rest home resident village quizzes. The van driver and carer accompany residents on their van outings.</p> <p>Rest home residents in the serviced apartments attend the serviced apartment programme or rest home programme. The activities staff have been successful in engaging residents in the engage programme especially around the pampering sessions and men's club as evidenced in the residents' survey results.</p> <p>Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six monthly. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Long-term care plans had been evaluated by registered nurses for long-term residents who had been at the service for a minimum of six months. Written evaluations for long-term residents describe the resident's progress against the resident's identified goals and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager, GP, care assistant and other allied health professionals involved in the care of the resident. 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.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location.</p>
<p>Standard 3.5: Surveillance</p>	<p>FA</p>	<p>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 resident files. Infections are included on an electronic register and the</p>

<p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>infection prevention and control officer (registered nurse) 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 meetings held at the facility. Meeting minutes include identifying trends, corrective actions and evaluations are available on the staff noticeboard. The infection prevention and control programme links with the quality programme. 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. An outbreak in 2016 was contained within the hospital unit and managed appropriately.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>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 six residents with restraint and one using an enabler. Enabler use is voluntary as confirmed by interview and documentation in the residents file.</p> <p>Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.</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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>The electronic incident report system includes templates for a variety of incident types. The form for some types of incidents does not include a specific place to document the details of this incident. For some incidents, staff had been creative around this but not all incidents were described. The clinical manager reviews all incidents but not all forms sampled had documented analysis to reduce the risk of recurrence. All incidents documented appropriate immediate response and clinical interventions as required.</p>	<p>Five of ten electronic incident forms sampled did not describe the incident that had occurred and did not document review and analysis to minimise the risk of recurrence.</p>	<p>Ensure all reported incidents include a documented description of what occurred and an analysis to minimise the risk of recurrence.</p> <p>60 days</p>
Criterion 1.3.6.1	PA Low	Monitoring forms in place include (but are not limited	Two respite files were reviewed (one	(i) Ensure respite

<p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>to); monthly weight, blood pressure and pulse, neurological observations (unwitnessed falls or identified head injuries), food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events. Long-term care plans reviewed documented all identified needs for residents, but respite resident files reviewed did not identify all current needs. The risk is identified as low and the issues were addressed on audit day.</p>	<p>rest home and one hospital level of care). (i) The initial care plan for the rest home respite care resident did not include interventions for identified falls risk. The blood sugar levels had not been completed twice daily as instructed on the care plan. (ii) The care plan for the hospital respite care resident had not been reviewed for the current admission to reflect changes in care.</p>	<p>care plans are fully completed and reviewed to reflect the resident supports and current health status. (ii) Ensure observations are taken and recorded as instructed on the respite care plan.</p> <p>90 days</p>
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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.