

Henderson Retirement Home Limited - Evergreen Retirement Home

Introduction

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

The audit has been conducted by HealthShare 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:	Henderson Retirement Home Limited
Premises audited:	Evergreen Retirement Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 11 May 2017 End date: 12 May 2017
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:	8



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Evergreen Retirement Home provides rest home level care for up to 17 residents. This unannounced surveillance audit was conducted against the Health and Disability Service Standards and the service contract with the district health board (DHB).

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The nurse manager is responsible for the overall management of the facility and is a registered nurse. The quality and risk plans and policies are implemented with data used to improve service delivery.

All requirements identified at the previous audit have been met. There are no requirements identified at this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents demonstrated they are provided with adequate information and that communication is open. Advance directives are signed by the resident

Regular resident and staff meetings provide feedback and confirm regular communication and involvement. If required, the service will access interpreters from the DHB. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. A complaints register is current.

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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There is a documented quality and risk management system that is designed to support service provision. Policies have been reviewed and the quality programme includes monitoring of service delivery. This includes review of incidents, accidents, infections, complaints with an internal audit schedule implemented and evidence of resolution of issues documented. Incident forms include documentation of notification to family and clinical follow up of the resident. Staff and resident meetings are held monthly.

Human resource policies are in place. Staffing levels reviewed are adequate across the service as per the staffing policy. Recruitment and employment process are implemented as per the policies with orientation and training provided.

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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Service delivery provides support and care for residents. The nurse manager completes the interRAI assessment, plans and evaluation of care with all staff documenting progress notes at the end of each shift. Residents and family confirm their engagement in the planning process.

Activities are individualised to each resident according to goals and activities of daily living. Residents are involved in a range of personal interest, education, employment, spiritual and cultural activities.

The medicine management system is described with an electronic system (Medimap) implemented commenced January 2017. Policies and procedures record service providers' responsibilities. Medication files documentation is completed as per policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. The menu has been reviewed by a dietician with recommendations implemented. Residents' dietary needs are identified on admission and reviewed on a regular basis. Residents confirm that adequate fluids and food is provided and snacks are available between meals.

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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All building and plant comply with legislation with a current building warrant of fitness in place. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Outdoor areas are available and well used. The laundry area has been labelled to indicate clean and dirty areas and chemicals are locked away when not in use. Fire equipment has been checked. All staff have a current first aid certificate.

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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Restraint policies and procedures include definitions of restraint and enablers which are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There are no residents requiring enablers on audit days.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. Infection control is an agenda item at monthly staff meetings. There is a documented surveillance programme with a low number of infections documented in the past year. Trends are reviewed.

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	22	0	0	0	0	0
Criteria	0	57	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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The service information pack includes information regarding informed consent. The nurse manager discusses informed consent processes with residents and their families during the admission process. The nurse manager confirmed their understanding of informed consent processes.</p> <p>The informed consent policy and procedure directs staff in relation to gaining informed consent. This includes guidelines for consent for resuscitation/advance directives. Staff ensure that all residents are aware of treatment and interventions planned for them, and that the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identify that the required consents are collected. Residents interviewed confirm that they give consent for all activities.</p> <p>All advance directives are signed by the resident, with one exception being signed by the general practitioner in line with the New Zealand Direction for Resuscitation. Family sign only to state that they have informed of the decision. The requirement identified at the previous audit has been met.</p>
<p>Standard 1.1.13: Complaints Management</p>	FA	<p>The complaint policy and procedure meets Right 10 of the Code and identifies that the organisation is committed to an effective and impartial complaints system. Complaints management is explained to the residents as part of the admission process and is part of the staff orientation programme and ongoing</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>education. Residents and family confirmed that they know there is a form that they can document concerns of complaints on and state that they would approach the nurse manager with any concerns.</p> <p>The complaints register records the complaint, dates and actions taken. There are no outstanding complaints at the time of the audit. Three minor complaints have been addressed as per timeframes in the policy with the complainant signing to indicate their satisfaction with the outcome. There are complaints raised through resident meetings with the nurse manager with these documented on the complaints register with evidence the complaints are followed up. The requirement identified at the previous audit has been met.</p> <p>There have been no complaints raised by external authorities since the last audit.</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>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure was available. Family members confirm that they are informed if the resident has an incident, accident, or has a change in health or needs.</p> <p>Family contact is recorded in residents' files. The current nurse manager rings or texts family at least twice a month. The nurse manager has been working with an external provider to attempt to reconnect a resident with family and is continuing to explore support for the resident.</p> <p>Interpreting services are available from the DHB. There were no residents requiring interpreting services at the time of the audit. Staff were observed to communicate with residents in a way that the resident could understand.</p> <p>The information pack is available in large print and could be read to resident if required. Residents are required to sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides rest home level of care under the aged care contract with the DHB. The service can provide support for a maximum of 17 residents with eight beds occupied on the days of the audit.</p> <p>There is a clear mission, values and goals documented in the business plan. These are communicated to residents, staff and family through information in the welcome pack and in staff training.</p> <p>The service is led by the nurse manager who started in the role in November 2016. The nurse manager also provided registered nurse support in a part time role for the service for three months prior to the role becoming full time. The nurse manager has a current annual practicing certificate; a level five certificate in</p>

		<p>business management; has worked in aged care for over five years and has experience overseas as the charge nurse of emergency department.</p> <p>A transition plan was documented and fully implemented after the last audit. The business, quality, risk and management plan is being operationalised with sign off of goals when actions are completed. The requirement identified at the previous audit has been met.</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>	<p>FA</p>	<p>Evergreen Care uses the quality and risk management framework to guide practice. This has been developed by an external contractor with policies updated yearly to three yearly depending on the policy and as changes occur. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. There is a document control process that ensures that correct versions of policies and procedures are used by managers and staff.</p> <p>The business, quality and risk management plan is operationalised. The nurse manager has been supported in the development of the quality and monitoring process by a registered nurse from the DHB. They have now completed their role with the quality and risk framework fully implemented.</p> <p>There is a risk assessment and management plan with this monitored through reports on quality indicators. There are specific quality improvement plans for issues that require greater resources or longer times to implement with these signed off when completed. Improvement plans have been completed around the laundry service; implementation of Medimap; new linen and furniture. Other projects are in the process of being implemented.</p> <p>Service delivery is monitored through the monthly staff meetings. Data around complaint; incidents and accidents; results from the internal audit programme and surveillance of infection data is discussed. Corrective action plans are documented with evidenced of resolution of issues.</p> <p>Meeting minutes provide evidence of communication with staff regarding aspects of quality improvement and risk management. There are resident meetings monthly that keep residents informed of any changes. The meetings also provide residents with opportunities to provide feedback and input into the quality and risk management programme. Family are contacted throughout each month individually and this allows them to have input into the service. Staff report that they are kept informed of quality improvements. There was a staff satisfaction survey completed last in 2016 with actions considered by the nurse manager and discussed through the staff meeting. The requirement identified at the previous audit has been met.</p> <p>A risk management programme is in place. Health and safety policies and procedures are documented along with a hazard management programme. The policies align with the Health and Safety at Work Act 2015. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are</p>

		<p>addressed or risks minimised or isolated. There is a hazardous substance register maintained</p> <p>The satisfaction survey is part of the internal audit scheduled to be completed annually. This was last completed in March 2017 with very positive feedback from residents and family. The results are tabled for discussion at the May 2017 resident meeting.</p> <p>Requirements identified at the previous audit around the quality plan; implementation of the internal audit schedule; resident meetings; satisfaction surveys; corrective action planning with evidence of resolution have been met.</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>	FA	<p>Policies require all incidents, accidents and adverse events to be reported immediately. Responsibilities are clearly identified. Incident forms are completed by staff when events occur. Families state that they are notified of any adverse, unplanned or untoward events with confirmation of this documented in the progress notes. All incident forms record evidence that family have been informed. The requirement identified at the previous audit has been met.</p> <p>Any resident who has an unwitnessed fall; potential or actual head injury or when a resident is not able to describe the incident has neurological observations taken for a period of time to ensure that the resident's condition is stable. The requirement identified at the previous audit has been met.</p> <p>Incident forms have been improved to include actions to be taken to prevent further incidents/accidents and evaluation of actions. The incident forms and evaluations are signed off by the nurse manager. The general practitioner (GP) states that staff inform them at the earliest opportunity if required following any incident.</p> <p>The nurse manager understands the obligations in relation to essential notification reporting and know which regulatory bodies must be notified. Staff state that they report and record all incidents and accidents and that this information is shared at all levels of the organisation.</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>	FA	<p>Policies and procedures identify human resources management that reflect good employment practice and meet the requirements of legislation. Newly appointed staff are criminally vetted upon employment and referee checks are completed for new staff. The requirements identified at the previous audit have been met. All applicable staff have a current visa on file.</p> <p>Professional qualifications are validated as part of the employment process and checked annually. The nurse manager has a current annual practicing certificate and a review of the nurse managers file confirms that all documentation is retained. The requirement identified at the previous audit has been met. Job descriptions describe staff responsibilities and best practice standards.</p>

		<p>Staff state that they complete an orientation programme. Copies of completed orientation was sighted in staff files sampled. The requirement identified at the previous audit has been met.</p> <p>Staff are provided with training and education related to their appointed roles with an annual training plan documented. Education records are retained in staff files and in training records. There are monthly staff meetings and training is provided for two hours after the meeting. Staff describe the training as being very useful and relevant to their roles. The nurse manager has completed interRAI training. The requirements identified at the previous audit has been met.</p> <p>Annual performance appraisals are conducted with these sighted. All staff have signed a new contract with the owners who took over the company in January 2017. There is a schedule for the completion of performance appraisals for 2017. The requirement identified at the previous audit has been met.</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>A policy identifies staffing levels and skill mix. Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care. The registered nurse/manager reports that additional staff would be rostered to meet residents' needs if required. Rosters reviewed confirm that staff are replaced when on annual leave or sick leave.</p> <p>There is always one health care assistant on duty at all times. Staff confirm there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. There are two cooks and an activity staff member to support residents. Maintenance is carried out by the owner. Residents interviewed state that all their needs are met in a timely manner.</p> <p>The nurse manager is on site five days a week and when required. They provide on call services and staff state that the nurse manager is available and responsive to any queries at any time.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Information is entered into the resident information management system in an accurate and timely manner. Information of a private or personal nature is maintained in a secure manner and is not publicly accessible. Archived records are stored onsite.</p> <p>Progress note entries are made by staff on duty on each shift. Records are legible and the name and designation of the staff member documented.</p> <p>Each resident has a file that includes assessment, planning and other information related to their care. Information is integrated with each page in the resident's file including the name and identifying details of the resident. The requirement identified at the previous audit has been met.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>Entry and assessment processes are recorded. Information is communicated to residents, family, relevant agencies and staff. The admission agreement defines the scope of the service and includes all contractual requirements. On the day of the audit, residents and family confirmed the admission process was completed in a timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care had been conducted.</p> <p>All residents have a needs assessment completed prior to admission to the service with all reviewed indicating that each resident is receiving the appropriate level of care. Admission agreements are completed on admission with these signed for any new residents on the day of admission. The requirements identified at the previous audit have been met.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The service has started using an electronic medicines management system (Medimap) with the staff member observed confidently using this when administering medication. This has resulted in a decrease in medication errors and there is no transcribing of information. The requirement identified at the previous audit around transcribing has been met.</p> <p>The medication area, including controlled drug storage, evidences a secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. Medication is checked on arrival to the service with a reconciliation form signed. The fridge used to store medications is maintained at a correct temperature for the medications stored. Temperatures are checked weekly. There is a process implemented to return expired medication to the pharmacy.</p> <p>Controlled drugs are stored in a locked cabinet in the locked medication room. A check of balances of controlled drugs in the register matched controlled drugs in the cabinet. There are weekly stock takes. Documentation of controlled drugs is completed by two staff in the controlled drug register and by two staff in the medication administration sheet. The requirement identified at the previous audit has been met. Staff sign for any lotion administered. This previous requirement has also been met.</p> <p>Staff authorised to administer medicines all have current competencies. The requirement identified at the previous audit has been met. Staff specimen signatures are recorded.</p> <p>Residents do not self-administer medications. The GP reviews each resident at least three monthly with this recorded on Medimap. There are monthly audits of Medimap and this ensures that all documentation is well maintained.</p> <p>Medication identified as required (PRN) includes the maximum dose and indications for use are documented.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service policies and procedures are appropriate to the service setting. The menu has been reviewed in August 2016 with a summer winter menu implemented. Observation on the days of audit confirmed that the cook follows the menu with this also confirmed by the cook when interviewed. This addresses the requirement identified at the previous audit. Recommendations made by the dietician have been implemented with evidence of resolution of issues. The food prepared for lunch and dinner at the unannounced audit was as per the menu.</p> <p>The cook confirms they are aware of the residents' individual dietary needs with these documented. The cook is able to respond to specific resident requests. The requirement identified at the previous audit has been met</p> <p>Resident files reviewed demonstrate monthly monitoring of individual resident's weight. Residents state they are satisfied with the food service, report that their individual preferences are met and adequate food and fluids is provided. Kitchen staff have completed food safety or higher training.</p> <p>Temperatures are recorded of the fridge and the freezer. Food temperatures are recorded. All temperatures are within normal range. Residents state that food is well presented and residents are satisfied with the meals provided. Meals observed indicate that these are hot when required and well presented with food tasted on the day being tasty.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The service has processes in place to seek information from a range of sources, for example; family; GP; specialist and referrer. The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery.</p> <p>There is evidence of residents' discharge/transfer information from the district health board (DHB), where required. The facility has appropriate resources and equipment, confirmed at staff interviews. Assessments are conducted in a safe and appropriate setting including visits from the GP. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p> <p>InterRAI assessments are completed six monthly; are current and individualised and the general practitioner has assessed the resident within 48 hours after admission for residents reviewed. The requirements identified at the previous audit have been met.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate</p>	<p>FA</p>	<p>Residents' care plans evidence interventions, desired outcomes or goals of the residents. In interview, residents and family confirmed their and their relatives' current care and treatments met their needs. Family communication is recorded in the residents' files.</p>

<p>and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>Progress notes and observation charts are maintained with a daily monitoring form completed for each resident by the health care assistant. Staff confirm they are familiar with the current interventions of the resident they are allocated. Short term care plans are completed for short term problems. Short term care plans are signed off by the nurse manager when the issue is resolved.</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 diversional therapist (DT) has completed a level seven health services certificate and is engaged as a health care assistant to provide activities to the residents for at least two hours a day. One other staff member is allocated to provide a further two hours a day for activities. The DT confirms the service has appropriate equipment. The DT has experience as a physical therapist and they plan and implements the activities programme. Health care assistants are to implement residents' activities according to the activities programme when the DT was not present.</p> <p>There is a monthly activity plan that is displayed in the communal area and in each of the residents' bedrooms. Regular exercises are provided along with intellectual and art/craft activities. The activities programme includes input from external agencies and people and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. Each resident has an individual assessment and activity plan and they are encouraged to continue with activities in the community. Residents' verbally feedback on the programme on a day to day basis and through the monthly resident meeting.</p> <p>Observation of the diversional therapist and the activities programme on the days of audit indicates that residents enjoy the programme, are provided with a range of activities including one to one activities and outings and their individual needs are met. The diversional therapist documents a monthly review of engagement in the activities programme for each resident and an attendance register is maintained.</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>Time frames in relation to care planning evaluations are documented. Residents' progress records are documented daily. When a resident's progress is different from expected, the RN contacts the GP, as required. Family are notified of any changes in the resident's condition, as confirmed at family interviews; as documented in communication records in each resident file and as confirmed by the staff interviewed. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p>
<p>Standard 1.4.2: Facility Specifications</p>	<p>FA</p>	<p>Documentation identifies that all processes are undertaken as required to maintain the current building warrant of fitness (expiry date in September 2017). Maintenance is undertaken by the owner or contractors as required. Electrical safety testing occurs annually. Clinical equipment is tested and calibrated by an</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>approved provider at least annually with this current (January 2017).</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. The service has cleaned all carpets in 2017.</p> <p>There are external areas with shade. There is a low gate with a pin code access for security and all residents are aware of the code. Residents and family members confirm that the environment is suitable to meet their needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The service has procedures in place for cleaning with staff able to describe how they complete cleaning tasks. There is a dedicated storage area for cleaning equipment and chemicals and all chemicals are locked when not in use. The requirement identified at the previous audit has been met. Cleaning is monitored by the nurse manager. The facility was clean on the days of audit.</p> <p>All laundry, including residents' personal laundry is completed on site. The laundry has clean and dirty areas as much as possible given the space available. Staff can describe how they separate laundry. The requirement identified at the previous audit has been met.</p> <p>Staff interviewed confirm they always have enough linen to meet day-to-day needs and there was plenty of linen in the cupboards on the days of audit.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency management policies and procedures guide staff actions in the event of an emergency. Emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. The nurse manager states that fire equipment is checked annually and documentation confirmed this. The requirement identified at the previous audit has been met. An approved fire evacuation scheme is sighted.</p> <p>Emergency supplies and equipment include food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking.</p> <p>The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation plan. All resident areas have smoke alarms and a sprinkler system. Emergency education and training for staff includes six monthly trial evacuations.</p> <p>All staff have a current first aid qualification. This address the requirement identified at the previous audit.</p> <p>Appropriate security systems are in place with staff checking that the premises are secure at night. Staff</p>

		and residents confirm they feel safe at all times. Call bells are located in all resident areas. Resident and family interviews confirm call bells are answered within an acceptable timeframe. Call bells randomly checked on the day of the audit are displayed and answered in a timely manner.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control coordinator (nurse manager) is responsible for the surveillance programme. Monthly surveillance data relating to number and type of infections is recorded with the following documented: individual records of each infection per resident; collation of data per site monthly; graphs of the data monthly; quarterly and annually and evidence that data is analysed and evaluated monthly including actions taken to address any issues or trends that are noted.</p> <p>Staff meetings are held monthly and meeting minutes show discussion of the data with a low rate of infections tabled. Staff report they are made aware of any infections of individual residents by way of feedback from the nurse manager through verbal handovers and progress notes.</p> <p>The infection control coordinator confirms that there have not been any outbreaks at the facility since their appointment to this position in 2016. Surveillance data was sighted and includes infection details related to files sampled.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded in policy. The restraint coordinator is the residential care officer/health care assistant.</p> <p>A low external gate is locked with a pin code. Staff state that the gate is locked to prevent unwanted people accessing the service from the community and so that some residents do not wander onto a main road. All residents have signed a consent form to indicate that they know the pin code and the reason for the gate being locked. All interviewed state that they can come and go as they please. There is a bell on the outside to ring for staff attention if they forget on the way back in. The requirement identified at the previous audit has been met.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews. There were no residents at the facility using enablers.</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.