Bethsaida Trust Board Incorporated

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:	Bethsaida Trust Board Incorporated
Premises audited:	Bethsaida Retirement Village
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 27 January 2015 End date: 27 January 2015

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: 43

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

Bethsaida Trust Board has rest home and hospital level care for up to 43 residents and all were occupied on the day of audit. The facility is managed by a nurse manager. All residents and family members spoken with were complimentary on the services provided.

This unannounced surveillance audit was conducted against a subsection of the relevant Health and Disability standards and contract with the District Health Board (DHB). The audit process included review of policies and procedures, review of residents and staff files, observation and interview with the manager, staff, residents and family members.

The service has addressed five shortfalls from the previous certification audit related to consumers' rights, organisational management, some medication management and infection prevention and control. Improvement continues to be required in medication management and consumers' rights and additionally the documentation around the complaints process requires improvement.

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.		Some standards applicable to this service partially attained and of low risk.

At the last audit an area of concern was raised related to the completion of advanced directives and the management of residents' money. These issues have been addressed, however the documentation of advanced directive as per the organisation policy remains an issue.

There is a complaints policy and procedure implemented by staff that has been used by residents and family/whanau. A current register of complaints is maintained by the manager who is responsible for managing all formal complaints. The response to complaints do not always meet the requirements defined in the Code of Health and Disability Services Consumers' Rights; this requires improvement. Complaints are reported and managed appropriately.

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.

Bethsaida Trust Board is a charitable organisation made up of voluntary board members who live in the Marlborough region. The facility is managed by a registered nurse who has business and administrative experience in the health sector. She is supported by a registered nurse clinical leader.

Bethsaida's quality management system is provided by an external contractor who specialises in the aged care sector. It is tailored to the facility and provides comprehensive processes to support safe and effective services. The Trust's vision, values, goals and objectives are documented in its current five year strategic plan which goes through to 2017. The current business plan, which guides quality and risk management activities, aligns with the strategic plan and the manager reports monthly to the Board against the plans.

There are appropriate quality and risk management activities which are planned and implemented at the facility. A quality, health and safety and infection control committee analyse collated data and take action to address trends. Risks are identified and management and control activities occur as planned. Staff interviewed and documents reviewed confirmed there was a robust event reporting system.

Safe staffing levels are maintained and safe employment practices are implemented. Current policies and procedures reflect good employment practices and their implementation is evident. There is an effective programme of ongoing staff development and training and staff interviewed confirmed that training is available and they are able to keep their knowledge and skills current. An area for improvement raised at the certification is now addressed and all new staff have police checks prior to appointment.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.

Two patients were reviewed in depth; one for a rest home resident and one hospital resident, in addition to review of four other clinical files to ensure consistency of practice. These reviews provided evidence of appropriate assessments being completed by registered nurses (RN), the resident's general practitioner (GP) and diversional therapist, in a timely way to inform care planning. There is coordination of service delivery based on the care plan and multidisciplinary evaluation occurred to meet the timelines of

the provider's agreement with the DHB (the ARC contract), or when the resident's condition changed. The changes to the ARC contract related to the charging for premium rooms was discussed with the manager who stated that all potential new residents and their family members are given a list of charges for rooms with premium rooms being of a bigger size. The manager reported that they have a waiting list for residents and rooms are allocated when they become available, there has been no resident who has moved room related to premium bed room charges, nor potential resident not accepted because of the room available being a premium room.

A monthly activities programme includes specific activities for hospital residents. Individual resident's activities plans are in place and one-on-one and group activities occur. Outings with staff and family were observed and celebrations in line with normal living patterns were described.

Improvements have been made to medication management since the previous audit, however issues remain in relation to medication management by GPs and documentation of administration by RNs.

Food services have recently been changed with the introduction of new menus. Special dietary needs are met and dietary supplements available.

Safe and appropriate environment

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

The facility has a current building warrant of fitness, which expires on 1 July 2015. All associated building systems were operational at the time of the warrant of fitness being issued.

There have been no alterations or additions to the facility since the last onsite audit. Fire evacuation practices are maintained and current.

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.

The facility has appropriate systems for the management of restraints and enablers to ensure the safety of residents who require the use of such equipment. On the day of audit there was one resident who uses an enabling device. All associated processes were completed to approve, consent, monitor and review the use of this device.

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.

There is a new RN/charge nurse who has recently taken over the role of the infection control coordinator. She has undertaken training, addressing a previous issue.

Surveillance activities are occurring with each resident's file containing a document to record any infection. A monthly report records infections within the organisation and an annual report allows for analysis and trending of data.

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	15	1	2	0	0	0
Criteria	0	38	0	3	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Negligible	There is a well described complaint policy and procedure that meets the timeframes and requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). The procedure is made available to residents and family members on entry to the service and is visible in the facility. Staff interviewed reported that they receive training in the Code and the organisation's policy, and they are able to support residents or family/whanau to make complaints. An up to date complaint register is maintained by the manager. All complaints received had been responded to appropriately and respectfully. However, a minor improvement is required to ensure that the specific timeframes in the Code are met in relation to the correspondence that is sent to complainants and is identified.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	PA Low	Areas identified as good practice that is appropriate to this services identified are the assessment forms and processes that inform the care planning. Care plans for all residents are comprehensive and updated at least every six months or when the resident's condition changed. At the last audit advanced directives in some residents' files were inconsistent with

		policy and the form used was unknown to the resident's GP. Improvements have been made to the process and in six files reviewed the advanced directive was completed with the signature of the resident or their relative/enduring power of attorney and the resident's GP. However, the form states that a red label will indicate the resident's wishes. This label was not sighted on any file reviewed, and the RN/charge nurse stated that this had recently been removed. The process is therefore not in line with the organisation's policy. A previous area for improvement identified was identified in relation to the management of residents' money held in the facility's office. There is now a process whereby two people always countersign any money coming in or out of each resident's fund held at the facility with clear records of this maintained. The system now in use is consistent with practice in the sector which safeguards both residents' funds and employees, with a traceable record of all transactions.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Event reports were reviewed with the manager. These record appropriate communication with family members. At interview the manager reported that residents and family members are given full and frank information at all times, and particularly when events have occurred. Residents' notes include recordings of communication to allow for the sharing of information amongst staff members as well families, and external health professionals. The organisation has guidelines for utilising interpreter services with this is required for any reason.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Bethsaida Trust Board develops a five year strategic plan which describes their mission, values and goals, and the objectives for the five year period. The current plan is for the period from 2012 to 2017. The manager reports monthly to the Trust board against the objectives of the strategic plan. At interview she reported that these meetings included the board members providing feedback on her reports, and any matters raised in them. Copies of the manager's monthly reports and minutes of the board meetings were reviewed and demonstrate the regular meetings and monitoring of the organisation's progress against its strategic plan. The manager is a registered nurse who also has business and administrative experience in the health sector. She has been in her position at Bethsaida for 18 months. There is also a clinical leader / registered nurse, was on leave on the day of the audit. There is a senior registered nurse who is able to provide back up to

		the clinical leader and additional nursing leadership on the floor. The manager and senior registered nurse were both on duty on the day of the audit. There is an external contractor who provides regular onsite support to the facility and manager. She also develops and maintains the documented quality management system and is a registered nurse with additional nursing qualifications relevant to the aged care sector. The external contractor provides regular onsite support to the manager, the documented quality management system and is a registered nurse with additional nursing qualifications relevant to the aged care sector.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The Trust board has engaged the services of an external contractor who develops policies and procedures for aged care facilities which meet the requirements of the Health and Disability Standards, district health board funded contracts for the provision of aged care services and ensures that these are tailored specifically to the organisation. This formal arrangement includes maintaining the documents, ensuring they are current and are revised regularly or when required. All documents reviewed during the onsite audit were current and were maintained within the organisation's document control system. Linking to the Bethsaida strategic plan is a business plan. This provided an annual programme of quality and risk management activities including a comprehensive internal audit programme and schedule of staff, team and specific meetings to manage different aspects of the quality programme. The internal audits encompass all aspects of the facility's activities (ie, service delivery, house-keeping, kitchen services and administration functions). The manager and clinical leader review the results of each completed internal audit, once the outcomes and any needed corrective actions are identified. These results and collated quality improvement data are discussed at the two monthly quality, health and safety and infection control meetings. The collated data is also shared at regular staff meetings and minutes of these meetings are available on the staff noticeboard for any staff who are unable to attend. The quality programme includes identification of quality improvement initiatives by staff members, residents and family/whanau. These are monitored through the regular quality, health and safety, infection control meetings and are included in the minutes. The manager has regular meetings with residents and if there are any issues which require a systematic and planned initiative to address them, these are

		brought to the quality, health and safety, infection control meetings to be discussed and addressed, and the issues are shared with all staff at the staff meetings. Corrective action plans are developed, as noted, in response to internal audits and when required in response to individual events, trends in events or systemic issues identified through the various meetings. The manager and clinical leader monitor the risk management schedule, which identifies risks to the facility and appropriate control measures to mitigate them. At interview, the manager demonstrated her understanding of these risk management activities, and her monthly board reports included evidence of these activities occurring. Interviews with the manager and nine staff confirmed that the quality and risk management programme is implemented as planned and staff understand their responsibilities for quality and risk management. They access meeting minutes if they are unable to attend a staff meeting and have received information about quality improvement initiatives and data when they attend meetings.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The adverse event policy and procedure includes the requirements for essential notification and when this is required. The procedure is a systematic process for the reporting and recording of all types of events which occur in the facility. Staff members interviewed demonstrate a good understanding of the procedure and spoke about their ability to routinely report events. The event logs were reviewed for 2014 and 2015 to the date of the audit, with the manager. These demonstrated consistent reporting, effective written reports by staff members and consistent review by a senior staff member (the charge nurse or clinical leader) and final sign-off by the manager. The data collated and discussed at the quality, health and safety, infection control meetings where any trends are identified and individual responses reviewed. Staff receive information about collated quality improvement data through the two monthly staff meetings and/or the information provided in meeting minutes.
Standard 1.2.7: Human Resource Management Human resource management processes are	FA	There is a suite of human resources management policies and procedures which provide a system of recruitment, appointment, performance management, training

conducted in accordance with good employment practice and meet the requirements of legislation.		and ongoing development of staff, reflecting good employment practices. The manager's role includes overall responsibility for the appointment of all staff. She monitors the qualifications of all employed staff who are health professionals (registered nurses) and ensures that their practising certificates are current. A copy of each registered nurse's practising certificate is kept on their personnel file. The recruitment, selection and appointment process includes reference checking and police-checking of new staff, addressing a previous area requiring improvement. There is a comprehensive induction and orientation programme which includes an introduction to the facility as well as training on relevant topics to staff working in an aged care facility. There are specific, tailored aspects to different roles so that each orientation programme is relevant to each role. There is a generic training schedule of in-service training to be scheduled annually and biennially at the facility. This includes a range of topics relevant to these standards including the Code, informed consent, hand hygiene and infection control, restraint minimisation and safe practice, medication management, first aid, manual handling and use of hoists and other assistive equipment and devices. In addition to this registered nursing staff have been supported to attend relevant external training to maintain their practising certificate requirements for professional development. Other staff have completed Careerforce qualifications in Support of the Older Person at either level 2 or 3 and other relevant qualifications depending on the staff member's role. Sampling of six personnel files verified that all aspects of the human resources management have been implemented. Additional sampling of training records (ten further staff members' records) confirmed completion of required training. Staff members interviewed reported that the training and development available to them was appropriate to their needs and enabled them to provide safe services to residents.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented process for staffing in the facility which includes the provision of nursing staff and health care assistants to meet the needs of residents, depending on their assessed level of care. A weekly roster is prepared which details the staff who are rostered on, by shift. This was reviewed during the onsite audit and reflects a safe number of nurses and health care assistants, and other

		staff within the facility. Staff members interviewed reported that there was a safe level of staffing at Bethsaida. The change from all rest home to a number of dual use (hospital level) beds at the last onsite audit, led to the appointment of a second cook to meet the nutritional needs of hospital level residents, as well as additional nursing staff. The roster for the current week and the following week were reviewed during the audit visit. They were consistent with the documented staffing process.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	Medications are prescribed by the resident's GP on a prescription chart, which is often faxed to the facility. It was identified at the last audit that this is problematic as some charts are reduced in size and therefore difficult to read. This remains the case. All medications are dispensed by external local pharmacies in blister packs. The checking of these was identified as an issue at the last audit, with a HCA checking medication blister packs and the inconsistent documentation of this checking process. The RN/charge nurse provided evidence that this has been addressed. Progress has also been made related to expiry of medications. These are now dispensed to each resident and no expired medications were sighted during this audit. The storage of medications, including controlled drugs, meets legislative requirement. The medication drug fridge temperature is monitored and the record of this shows that it was at an appropriate level. The medication administration process was observed during audit and discussed with the RN undertaking the process. Good practice was observed. Two charts reviewed did not have the signature of the RN who had administered the medication the previous lunch time. This was reported to the RN/charge nurse. RNs usually undertake medication administration. There are four HCAs trained in the administration process who are able to assist as required and in an emergency situation. The RN interviewed stated that some residents are able to self-administer medications and a form for this purpose was sighted in one resident's medication chart. This shows that the GP and an RN have assessed the resident to undertake this and this is reviewed annually.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The cook is interviewed and stated that the menus have recently changed with input from an external provider who is aware of the guidelines that are required to be met. This is confirmed by the RN/charge nurse. However, there was no documented evidence that the new menus had been reviewed by a registered dietitian. The manager is aware of this and action is underway for this to occur. The new menu had only commenced the week prior to the audit and the previous menu had been reviewed by a registered dietitian. The new menus were reviewed with the cook and these showed a varied menu with many variations to meet the needs of special diets. Soft diets and minced diets are available and were in use during the lunch observed. The cook spoke of dietary supplements being available and thickening for liquids were available in the unit. A tour of the kitchen was undertaken with the cook and this was noted to be clean with good areas for preparation and serving from a Bain Marie. Temperatures of fridges, chillers and the freezer was undertaken and within required limits. There is an ongoing problem with the freezer which has been brought to the attention of the Board. Food serving temperatures are recorded and are at an appropriate level. All food stocks are dated and rotation of stock has occurred. There is specialised crockery and cutlery available to residents and staff were observed to be attentive at lunch time to assist residents with meals.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	There was evidence in the files reviewed of assessments occurring. This was seen in the first instance occurring as part of the initial assessment and care plan, with a full comprehensive assessment occurring within three weeks of admission. These assessments include falls risks, pressure area risk, pain, skin and wound, continence, and an overall risk assessment to identify the resident's acuity. These assessments are used to inform the long term care plan. The long term care plans are comprehensive covering all necessary aspects of care required. Each section had an area to record goals/outcomes, interventions and evaluation and changes to interventions. In the six files reviewed these are completed within the required timeframes or when the resident's condition changes. The nursing/care progress notes sheets document the completion of care provided by healthcare assistance (HCAs) and RNs in line with the needs of the residents. Each of the six files reviewed contained an individualised diversional therapy

		(recreation) care plan completed within a week of admission by the diversional therapist and reviewed following changes to the resident's condition or six monthly review. The resident's GP documents in the clinical record and there is evidence of assessment, plans of care and review of the resident at least three monthly or more often if required. Two GPs spoken with stated a confidence in the staff to contact them if the resident's condition required this. There is evidence in the files reviewed of transfer to the local hospital when the resident's condition deteriorated.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	FA	A trained diversional therapist (DT) and two diversional assistants provide a monthly programme for all residents. Hospital level residents have a dedicated hour a week which has increased with the number of hospital resident. The January programme was reviewed and the DT interviewed. The DT stated that the programme is reviewed annually and changes made from feedback. The programme covers activities such as reading, housie, and a social evening 'happy hour'. The DT spoke of celebrations, such as Christmas lunch and birthdays, including families. External groups also come to the centre and pets are often brought into visit residents. It was observed that staff and family members take residents on outings. Hospital residents can also be taken on outings with the use of the Red Cross mobility van. The DT spoke of completion of the recreation and DT care plan once the new resident has settled into their new surrounding and this was completed in most files reviewed within a week of admission by the diversional therapist. The care plan outlines the goals and outcomes for each resident. There is also an individual activities attendance register and progress and evaluation notes. The DT spoke of meeting the individual needs of residents and taking time with one-on-one sessions for 'unsettled' residents and / or those who do not wish to participate in the group activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Evaluation of residents is evident in the six files reviewed. There is monthly monitoring of residents' observations and weight and where appropriate these are increased. A six monthly review of residents is carried out and a calendar of when these are due is maintained. The six monthly review is at a multidisciplinary meeting, with the resident and their family made aware of the meeting and invited to attend. Two relatives spoken with were aware of the meetings and are kept up to date by staff in relation to their relative's progress. In four residents' files reviewed the

		multidisciplinary meeting form stated who attended the meeting. The resident's outcomes/ goals were reviewed and care requirements reviewed, changes required were then transferred to the care plan and the DT care plan. In files reviewed it was identified that when the resident's condition deteriorated action was taken and transfer to hospital was facilitated in the case of two files reviewed. Medication prescriptions are adjusted based on results of monitoring, where this is applicable.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is current building warrant of fitness for Bethsaida. This was issued in 2014 and expires on 1 July 2015. All building systems and functions reviewed during the building warrant check were fully operational. The facility has been purpose built by the Trust and is appropriate to the needs of older people. Floor coverings and surfaces are even and can be negotiated safely by residents. There are hand rails through-out the facility and a number of available seating areas. The buildings are surrounded by accessible gardens and pathways which have been designed to be safe for residents to use. Residents observed at the facility during the audit visit were able to move about the building, some using mobility equipment and some independently.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	At the last audit the RN with the responsibility for infection control had not under taken training related to this responsibility. The RN/charge nurse has taken over this role and the responsibilities document was sighted. The RN/charge nurse has undertaken infection control training and discussion on maintaining currency occurred, such as through the Southern Community Laboratories. The manager and a further RN who are members of the infection control committee are booked to undertake infection control training in Wellington this year.
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	In the six files reviewed an infection register was sighted. The RN/charge nurse provided evidence of monthly reporting of infections. She spoke of infections being those where the GP diagnosed and treated the infection and this may be supported by laboratory finding. The monthly infections recorded for the last thirteen month was sighted and an annual report for 2014 showed evidence of analysis and trending occurring. The RN/charge nurse was new to this role and stated that this process will be used on an ongoing basis and the reports will be discussed at the

		infection control meetings.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a restraint minimisation and safe practice suite of policies and procedures, which includes the voluntary use of enablers and utilising the least restrictive options to meet residents' needs. The overall intention is to have a restraint free environment if at all possible. This has been achieved and the only device currently in use is for a resident who uses a wheelchair for mobility and requires a lap belt for safety. Review of the resident's file demonstrated that the organisation's process for use of enablers had been followed. This included an assessment of need, consent, monitoring when the equipment was in use and review of the need for the enabling equipment. The same resident had had another type of enabler for a period of time but at a review its use had been ceased. Two staff interviewed described the enabler process at Bethsaida and the specific equipment used by this resident.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.13.1 The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.	PA Low	Four complaints have been received since December 2013 and all resolved to the satisfaction of the complainant. Records maintained demonstrate that there has been a combination of verbal and email and other written communication in response to complaints. Complaint management and interaction with complainants has been respectful, and fulfils the requirements of Right 10 for addressing complaints. In two of the complaints an acknowledgement letter was sent more than five days after the complaint was received, although a verbal acknowledgement had been given within five days. In a third complaint no written acknowledgement letter was sent, although verbal acknowledgement had	There is an easily accessed, responsive and fair complaints process, which is documented and complaints are managed well, however, the timeframes of the Code are not always met with the written correspondence sent in response to complaints.	Ensure that all written correspondence in response to complaints is sent within the timeframes required by Right 10 of the Code. 180 days

		been made within five days and was ongoing and frequent. Other written correspondence in response to these complaints has not been sent at timeframes required by Right 10 of the Code given the date the complaint was received.		
Criterion 1.1.8.1 The service provides an environment that encourages good practice, which should include evidence-based practice.	PA Low	There had been changes to the advanced directive process since the last audit, with the resident's GP signing the form. All six residents' files reviewed had completed advanced directives. The form states that the resident's wishes will be indicated by a red sticker in the file; however this was not seen in the six files reviewed.	None of the six residents' files reviewed had a red sticker to indicate the resident's advanced directive for resuscitation as stated on the form and organisation policy.	The process for advanced directives is reviewed with staff and changes made as agreed to the process and/or policy as required. 180 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	The management of medications has been improved since the last audit, however in the nine files reviewed and through observation of a lunch time medication round ongoing issues were identified. Not all medications were discontinued as per policy, as required (PRN) medications do not have the indication for administrations consistently documented. A number of medication prescriptions that had been faxed to the facility were reduced in size through the process and this made them difficult to read. The RN administering the medications identified that in two charts the lunch time medications had been given but the RN had not signed the administration form.	In nine residents' medication charts reviewed there was evidence of inconsistent practices. In two cases, as required (PRN) medications did not give the indications for use; medications discontinued in three cases did not include the date and/or signature. In one case a medication had been re-charted at an increased dose but the lesser dose prescription was not discontinued. In two cases the RN had not signed as having administered the medication.	GPs document the indications for use of PRN (as required) medications and follow policy in relation to discontinuation of medicines. RNs sign the medication administration chart as per policy. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.