

# Calvary Hospital Southland Limited

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## 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:

<b>Legal entity:</b>	Calvary Hospital Southland Limited
<b>Premises audited:</b>	Calvary Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 10 November 2015    End date: 11 November 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	69

# Executive summary of the audit

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## 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

Calvary Hospital, in suburban Invercargill, Southland, continues to provide rest home and hospital services for up to 72 residents. A Board of Directors governs the organisation, which is also supported by local community grants.

The well-established quality and risk systems provide a framework on which service delivery is based. Positive reports about the quality of care being delivered were provided and staff retention is a feature. This service is accepting people with increasingly complex needs and the service is responding to this by ensuring staff training meets these.

This unannounced surveillance audit showed that three of the four previous corrective actions required have been fully addressed. Progress has been made around the recording and delivery of staff training, although some gaps persist. One other area requiring corrective action is related to the need for the activities coordinators to gain additional skills in the reviews and evaluations of personal goals.

## 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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According to the evidence provided, open disclosure is consistently occurring following any incident and there are open communication lines between staff, residents and family. There has not been any need for use of an interpreter service; however information about such services is available in the policy and procedures.

A complaints process that meets the requirements of the Code of Health and Disability Services Consumers' Rights (the Code) is in place and the few complaints that have been logged are in a register, which details the response process for each.

## 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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An experienced and suitably qualified manager who undertakes ongoing professional development reports to a Board of Directors. A mission statement and quality philosophy is documented and recently developed values are displayed throughout the facility. There is a current strategic plan that aligns with a quality and risk management plan.

The quality plan guides the implementation of the quality and risk management system, which is recorded in well documented meeting minutes each month. These minutes and a series of staff and residents' meetings are platforms for the management to keep everybody informed about quality and risk related issues. Policies and procedures are document controlled and the review process of these is being maintained.

Key elements of the quality system are the analysis of data and implementation of strategies to address identified shortcomings related to complaints, incidents/accidents, infection control, internal audits, service delivery issues, corrective actions and restraint, for example. The review of incidents has resulted in a falls prevention project and more recently an investigation into the incidence of skin tears.

Professional qualifications are being checked, processes to ensure suitable staff are employed are in place, an orientation programme is being upheld and a range of education opportunities is accessible to staff, although not all caregivers have completed training requirements.

Rosters reflect policy documentation around staffing of the facility. The facility is being staffed in a safe manner with suitably qualified and sufficient numbers of staff on duty at all times.

## 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.
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Assessment processes in place provide guidance for the development of service delivery plans. The interRAI assessments are being supplemented by more specific assessments when indicated.

Long term care plans with goals and interventions are being developed within three weeks of admission. Short term care plans were in place, as were wound care plans for residents/patients who had breaks in their skin integrity. These are being reviewed every one to two days. In addition, comprehensive progress notes are written each shift, six monthly multidisciplinary reviews are being completed and specialist reviews instigated when indicated.

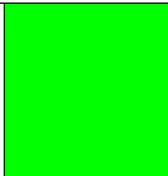
A varied activities programme ensures different interests are catered for, interdenominational pastoral care is available and there is evidence of integration with the wider community.

Medicine management is being supported by an e-prescribing system that uses a cloud based shared interface. Medicines management is being undertaken in a competent and safe manner.

A dietitian continues to oversee the food and fluid management in this facility. The Hazard Analysis and Critical Control Points (HACCP) programme supports food safety and kitchen staff training systems.

Issues related to the corrective actions raised at the previous audit had been addressed following a full review of the care planning documentation and staff retraining.

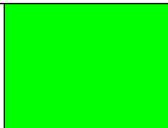
## Safe and appropriate environment

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

Although renovation has been undertaken, there have not been any modifications to the building since the certification audit.

## 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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The organisational policy and procedures on restraint minimisation includes a definition of enablers that reflects their voluntary nature. There have not been any restraints used at Calvary for 27 months. According to the restraint register there are twenty enablers being used. Assessment, agreement and monitoring processes are being maintained. A report on restraint and enabler use is presented to quality management meetings.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

An infection control coordinator is responsible for the surveillance of the incidence of infections. The data related to the type, person and interventions and outcomes is collated, analysed and reported to the quality team on a monthly basis. Recommendations are made and actions taken when indicated. For example, a comprehensive project on urinary tract infections has been in place for the past three months and staff have responded positively to this.

## 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)
<b>Standards</b>	0	17	0	2	0	0	0
<b>Criteria</b>	0	41	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	FA	<p>The organisation's complaint process is described in a policy document, which includes a complaints form, a flow diagram, a process for receiving a complaint and one for acknowledging a complaint. All documents are consistent with Right 10 of the Code. Residents and relatives did not have any complaints to report, staff described actions they would take if a person approached them with a complaint, and complaints forms are available throughout the facility.</p> <p>A complaints register includes three complaints for 2014 and one for 2015. Details of the complaints, the responses, dates and people involved are available. The folder that the register sits in includes the documentation related to each respective complaint. Likewise, there are compliment registers and related documents for 2014 and 2015.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide</p>	FA	<p>A policy on open disclosure is in place. Residents noted that there are open communication processes with all staff, including the managers. Relatives stated they are informed when any change occurs for their family member. Three months of incident reports showed the time and date family were contacted, or an explanation documented the reason why not. Records of family contact are also in progress notes viewed.</p> <p>The manager advised that they have access to the local district health board interpreter service and that there has not been any need for interpreter services for some years, when a staff person assisted communication with a</p>

<p>an environment conducive to effective communication.</p>		<p>resident whose first language was not English. An interpreter policy includes how the service will meet the needs of people with visual and auditory impairment as well as those who speak other languages.</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>A mission statement for this service reflects the religious ethos of the organisation. The strategic plan for August 2012 - July 2016 describes the goals and objectives of the organisation, action plans, person(s) responsible and the dates of implementation. It includes progressive updates on the level of achievement for each goal. The plan notes that the owner is the Calvary Hospital Southland Foundation; the manager of the enterprise is Calvary Hospital Southland Limited. The members of the Board of Trustees/Directors are listed and the plan has aspects of the quality and risk integrated through it. There is a focus on community relationships, fiscal responsibility, governance, provider services and mission effectiveness. Other documents on organisational planning processes and considerations for strategic development of the service were also provided.</p> <p>The current facility manager has been in the role for more than seven years. She is supported by a finance manager and a clinical manager as well as the Board of Directors to whom she provides monthly reports. With a nursing registration, specialist nursing expertise, prior nursing management experience and post-graduate qualifications in management, she is suitably qualified and experienced. There is documented evidence that professional development is being maintained through attendance at training days provided by the Chamber of Commerce and by the New Zealand Institute of Management as well as a variety of specialist topics and conference attendances.</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>An organisation wide quality and risk management plan July 2015 – June 2016 defines its quality philosophy and describes the symptoms of continuous quality improvement. It refers to the different quality frameworks, legislation, national standards and contractual requirements that the organisation is adhering to. The plan includes a flow-chart, a set of quality improvement objectives and a set of health and safety objectives.</p> <p>Protocols around policy and procedure manuals that underpin the operations of the service are described in the quality plan. These are reviewed two yearly, as per the objectives of the plan. The documents sighted during the audit were document controlled, as per the policy on the control of organisational documents.</p> <p>A team of staff have been allocated roles of responsibilities around issues such as restraint minimisation, infection control or maintenance. Each reports their topic back at the quality team meetings with a set of quantitative data, possible contributing factors, recommendations for change (if required) and any continuous improvement. A number of staff members are asked to participate in the internal audit programme and will complete the audit tools for the clinical coordinator. Results are reported through the quality system.</p> <p>The minutes of monthly quality team meetings are comprehensive and the minutes for the last five months were sighted. They described quality related initiatives and changes that have been made for quality improvement</p>

		<p>purposes. Examples of topics discussed include reports on accidents/incidents, internal audits, infection surveillance, restraint monitoring, maintenance issues, the hazard register, health and safety, staff education and service provision. Staff, residents and relatives confirm that meetings are organised and are platforms for people to hear about what is happening within the wider organisation, to make suggestions and to express any discontent. Minutes of these various meetings are recorded.</p> <p>The Calvary risk management plan 2015 – 2016 focuses on the actual and potential outcomes if the aspects of the quality plan, such as policies and procedures, are not upheld, or if authorised standards/contractual requirements are not maintained. The plan describes how the organisation is pro-actively integrating risk management into its culture by identifying and addressing risks at individual resident, relative, staff, organisational/service delivery, community and board levels. It notes the category each issue fits into and details review timeframes and the platforms for each.</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>There are policies, procedures, flowcharts and forms related to the management of incidents and accidents.</p> <p>The facility manager and the clinical coordinator were able to provide examples of their responsibilities around essential notification, which included the reporting of serious infections/outbreaks, unexpected death of a resident, change in management, potential breaches of contract and serious accidents. Examples of the personnel and establishments to be reported to included: the Ministry of Health, the portfolio manager in the District Health Board, the police and Worksafe NZ.</p> <p>Processes around the collection of accident/incident data, analysis of the data and the identification of possible interventions to improve service delivery, were discussed. The data is collected in a manner that facilitates analysis and is enabling the management to use it to reduce incidents. An example provided was that falls were more frequently being reported between 4pm to 8pm. A strategy was implemented to reduce the incidence. Currently there is a focus on the prevention of skin tears as it was noted that the numbers had increased. An incident register is in place, reports are provided to the health and safety and quality team meetings monthly and graphs are developed annually.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good</p>	PA Low	<p>A folder contains a master list of annual practising certificates and when they fall due, for registered and enrolled nurses, podiatrist, dietitian, physiotherapist, pharmacists and attending general practitioners. Copies are on file and show professional qualifications are being validated and scopes of practice and currency of their registrations are being checked.</p> <p>Although human resource policies and procedures are currently under review, those in place describe what is happening. New staff are required to complete a job application form, present curriculum vitae and undergo a police check. A minimum of two referees are contacted. The manager spoke of consultation processes with other</p>

<p>employment practice and meet the requirements of legislation.</p>		<p>staff before accepting a new staff person. Records of these processes are in staff files checked during the audit.</p> <p>An orientation/induction programme is in place and a coloured booklet (coded according to the position). The education co-ordinator oversees new staff orientation and ensures that the required competencies and education are completed within the first months of employment.</p> <p>A twelve month staff training programme is in place and covers a diverse range of topics including mandatory training. The manager funds staff to attend external training relevant to the field and/or current residents. Two identical training days for enrolled and registered nurses are provided and two separate ones for hospital aides/caregivers. These are mandatory for staff to attend as per the roster. Half hour training topics are also provided throughout the year. A system to record staff education has been developed and more clearly demonstrates what training each staff person has attended. The system to record staff training and the lack of uptake of mandatory training was a previous corrective action. Despite the improvements in managing staff training and the efforts to attract staff to attend staff development sessions, there are still gaps in the records of staff attendance for mandatory training topics.</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>	<p>FA</p>	<p>A policy and procedure describes the requirements for staffing the facility and outlines the issues that will influence increasing or decreasing staff numbers such as acuity, weekends or managers' presence. Staff spoken with informed that they are comfortable with staffing levels and consider them adequate. Auxiliary staff include cleaners, laundry workers, a dietitian, cooks and kitchen hands, activities coordinators, a physiotherapist and physiotherapy aides. Hospital aides/caregivers, registered nurses and enrolled nurses are rostered according to the roster framework and the manager described how she ensures sick and annual leave are covered.</p> <p>There are different frameworks for the rosters in the hospital and the rosters for residential (rest home), both of which were sighted and discussed. A registered nurse is on each shift in the hospital, including night shift, and a second in charge who may be an enrolled or a registered nurse is on morning shifts. Most days, the people in these positions do not take a patient workload. The manager and clinical coordinator, both of whom are registered nurses, work Monday to Friday and one or the other of these are available on call outside normal office hours. The residential service has an enrolled nurse on morning and afternoon shifts who is overseen and assisted by the hospital registered nurse when required. Three weeks of rosters for both the hospital and for the rest home were reviewed and all meet the staff allocation requirements and employment legislation.</p> <p>Overall, there are adequate staff numbers and there are sufficient numbers of qualified professionals to enable appropriate and safe services to be provided. Additional staff are rostered when residents/patients become unwell or a person requires palliative cares.</p>
<p>Standard 1.2.9:</p>	<p>FA</p>	<p>Short term care plans are now recorded within hospital and rest home residents'/patients' personal records.</p>

<p>Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>Information from multidisciplinary team meeting notes pertaining to individual hospital patients is now being transferred onto their care plans and rest home residents now have personal profiles and evaluations within the relevant residents' records, rather than collectively as previously. The corrective action raised at the certification audit regarding aspects of client records not being integrated into individual / personal files has been addressed.</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 various aspects of medicine management are being undertaken safely. Medicines are stored in rooms locked by a numeric keypad and are administered from a mobile trolley. A medicine management round was observed and staff demonstrated care and competence in the administration of medicines. Controlled medicines are being checked and stored as required. Unused medicines are returned to the pharmacy for disposal.</p> <p>The facility uses Medi-Map to assist in the management of medicines. This cloud based medication charting system with a shared interface enables the pharmacy to receive the orders for residents' medicines direct from the prescriber and they are subsequently delivered to the facility. Records show that this is occurring on the same day. Staff managing medicines have also completed competencies through Medi-map around its use. Only registered and enrolled nurses have a medicine management competency, which is reviewed annually. Documents sighted show that all are current.</p> <p>Only one person self-medicates and this is for the administration of one medicine only. Although records show a three monthly self-medication competency review system is in place, the dose is checked and signed off by a staff person with a medicine administration competency.</p> <p>The e-prescribing system is enabling allergies to be recorded and these were in place in the medicine records checked, or nil known recorded. Staff sign-off is evident and the once weekly checks (at least) by the clinical coordinator enable any non-compliance to be identified and the cause investigated. The system enables clarity between regular, as needed and short term medicines.</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</p>	<p>FA</p>	<p>A dietitian employed by the service for eight hours a month oversees the nutritional needs and fluid management of the residents and is currently reviewing the two summer and one winter menu for the service. The dietitian informed that she goes in to see any new resident with such needs, will monitor people whose condition is deteriorating or whose nutritional needs have inexplicably changed and has attended residents' meetings to respond to complaints about food.</p> <p>A nutritional needs assessment is completed on admission for each person and includes their likes and dislikes. This information is provided to the kitchen where a master list is available. This was viewed in the kitchen and</p>

<p>service is a component of service delivery.</p>		<p>shows that changes are ongoing. The cook described the manner in which they ensure people receive the food according to their assessed needs and personal preferences. The textures of food are modified when required and this was evident when the midday meals were served on the two days of audit.</p> <p>The service undertakes the Hazard Analysis and Critical Control Point (HACCP) programme to ensure food safety. The temperatures of hot food before serving, frozen goods on arrival to the facility and fridge and freezer units are being recorded daily and as appropriate and follow-up actions taken when required. Examples of these were provided and related documentation was sighted. Foods are being stored according to safe practice and leftovers labelled with the date and disposed of within 24 hours if not eaten. Staff have completed safe food handling training. Food waste is disposed of through an 'insinkerator' or through local rubbish disposal systems in plastic bins with coloured tops according to the type.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>During the certification audit, it was identified that information gained in the initial and ongoing assessment tools was not always being transferred to the goals section of patients'/residents' long term care plans. InterRAI assessments had been used in seven of the nine files reviewed during the surveillance audit. However, all needs and required outcomes of the patients/residents identified via either the electronic or manual assessment processes had been integrated into the goals sections of care plans of the personal files reviewed. The issue identified for corrective action was not evident in the nine client files reviewed during this surveillance audit.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>As in standard 1.3.4 above, information obtained through assessment processes had not been transferred to the care plans, however for this standard there had been an absence of strategies/interventions in the care plans that would address the identified needs or required outcomes.</p> <p>The nine client files reviewed during the surveillance had plans, interventions and/or strategies to address all needs and required or preferred outcomes identified from the initial and/or on-going assessment and evaluation processes. Hence, the issues raised for corrective action during the certification audit were no longer evident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	<p>FA</p>	<p>Assessments, care planning and evaluation processes are contributing to the residents/patients receiving adequate and appropriate services. Internal and external health professionals who were interviewed during the audit are confident that high levels of care and assistance are being provided and that additional expertise is accessed when indicated. The residents and relatives expressed satisfaction and readily gave the staff and management accolades for the services provided. Progress notes are comprehensive and describe changes that occur. They include accurate records of actions taken, or consultations made (including with family/whanau).</p>

assessed needs and desired outcomes.		
<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>	FA	<p>Monthly activity schedules are developed by the activities coordinators who described their roles and responsibilities. The schedule shows that activities cover the spectrum of spiritual, physical, mental and emotional. Residents and relatives applauded the work of the activity coordinators and told stories of their involvement. A range of options are being offered in many different settings and there is a focus on pastoral care.</p> <p>Each person has a completed personal profile in their care plan and a section of the plan is devoted to a social and recreational goal and its implementation. Individualised preferences and levels of ability to participate are evident and the goals and interventions reflect the resident/patient profile obtained on admission. Photographic records of residents' involvement in the activities programme were also viewed. There is a need for improvement in the ongoing progress recording and evaluation of the personal social and recreational goals, as identified in criterion 1.3.3.1.</p> <p>Although there are variations in the activity programme for the hospital and for the rest home, joint activities are often organised. The community is well integrated with volunteers helping in the facility as well as activities being organised that the wider community are invited to participate in.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Short term care plans and wound care plans are being reviewed and evaluated every two days by the registered nurse/clinical coordinator. There is evidence that reviews occur should the condition of a resident/patient change and additional expertise is accessed when indicated. Otherwise six monthly multi-disciplinary reviews and evaluations of progress against goals are consistently occurring for all residents. The multi-disciplinary (MDT) process enables all people involved in the care and wellbeing of the resident/patient to contribute to the process. Feedback is entered into a template form and discussed at a meeting to which the resident and family member is invited. There is evidence of changes having been made to care plans according to MDT input. Except for the section on social/recreational, as noted under criterion 1.3.3.1, this system is ensuring service delivery plans are evaluated in a comprehensive and timely manner.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	FA	<p>The building has a current warrant of fitness issued on 5 February 2015.</p> <p>There have not been any alterations to the building since the last audit; therefore no other aspects of this standard were audited during the surveillance visit.</p>

for their purpose.		
<p><b>Standard 3.5: Surveillance</b></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 programme describes the surveillance objectives, foci and processes. These include ongoing infection prevention audits, staff education and annual reviews, the last of which was undertaken in July when a change to reporting processes was made. Any incidence of infections is recorded on an infection control notifying form and the details are transferred onto a monthly infection recording form where they are categorised. Records are separated for the hospital and the rest home; include details of those on prophylactic antibiotics and the number of repeat infections. The infection control officer analyses these results monthly. Any increase or decrease in incidence, or possible reason(s) for changes in expectations is identified and recommendations suggested. Comparisons with previous months and years are also made.</p> <p>Three projects have emerged as a result of the surveillance of infections. A peak of urinary tract infections earlier in 2015 has prompted the introduction of yellow stickers that are placed in residents' records and have a tick box to guide staff actions for when a person has an infection. Hand hygiene has been promoted, and an information poster on urinary tract infections and prevention strategies has been developed and displayed in various parts of the building. The infection surveillance reports are presented to the quality team meetings and the board on a monthly basis. Annual reports also go to the board of directors.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Organisational policies and procedures promote the minimisation of the use of restraints and state the voluntary nature of enablers. Assessments are undertaken prior to the use of an enabler and the form specifies that the resident/patient has agreed to its use it for their safety, or has asked to use it. Any use of enablers or restraints is reported to the monthly quality meetings and to the board. Staff demonstrated during interview that they are aware of the difference between restraints and enablers and are proud of the limited use of restraint in this facility. They noted people ask for bed rails to help them turn in bed or to help them feel safe from falling out of bed. The latest report on restraint minimisation (October 2015) states there are 20 enablers currently being used, most of which are bed rails, and that there has not been any use of restraints for more than two years. The restraint register was sighted. This includes the use of enablers and is updated every three months.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>Progress has been made in ensuring new staff undertake appropriate training related to the care of older people within six months of employment. All caregivers/hospital aids have completed their aged care education programme; or their national certificate in health, disability and aged support; or have commenced such a qualification; or have not yet been working at the service for six months. Ongoing internal and external staff training opportunities that include mandatory attendance at one of two study days per year are provided. Training records demonstrated that there are still gaps in staff gaining and/or maintaining mandatory training requirements. A finding in 1.2.7.5 is recurring from the previous audit.</p>	<p>The system implemented to record staff training is now up to date; however there continues to be gaps in staff attendance at ongoing staff development sessions provided.</p>	<p>Staff training programmes will relate to the services being provided and attendance at staff training opportunities are maintained according to organisational requirements.</p> <p>180 days</p>
<p>Criterion 1.3.3.1</p>	PA Low	<p>As detailed in standard 1.3.7, a credible and varied activities programme is in place. Personal profiles are developed for</p>	<p>A social and recreational programme of activities is</p>	<p>Subsidised residents'</p>

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>		<p>residents and patients and each has a social/recreational goal with strategies for implementation. Participation records are held in the office of the activities coordinators. Reviews and evaluations are being done six monthly, mostly by a registered or enrolled nurse. The activities coordinators are highly skilled in the delivery of the activities programme, and link with a local group of diversional therapists and activities coordinators on a monthly basis; however they have not undertaken the related training that would ensure the personal goals are reported on, reviewed and evaluated as required by the standard.</p>	<p>being implemented; however the people implementing this have not undertaken relevant training and the progress reporting and evaluations of activities goals are mostly being written by nursing staff and do not necessarily reflect the personal goals.</p>	<p>personal activities goals are developed, reviewed and evaluated by a person skilled in and accountable for assessment and evaluation of social, diversional and motivational recreation programmes.</p> <p>180 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.