# Stanthom Properties Limited

## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Stanthom Properties Limited

**Premises audited:** San Michele Home and Hospital

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 23 March 2016 End date: 23 March 2016

**Proposed changes to current services (if any):** The provider has requested that verification for hospital-medical (non-acute) be added to the services being provided.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 28

# 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 |
|  | 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

San Michele Home and Hospital (San Michele) is privately owned and provides rest home and hospital level care for up to 29 residents.

The provider is wishing to provide non-acute hospital level medical care and this audit also verified requirements for this.

This surveillance audit was conducted against the required Health and Disability Services Standards and the provider’s contract with the district health board. The audit process included the review of relevant policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff, and a general practitioner.

There were 10 areas identified for improvement in the previous audit all have been addressed by the service.

There are three new areas identified for improvement related to staff education planning, assessments of residents, and policies and procedures specific to gaining hospital-medical (non-acute) certification.

## Consumer rights

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| 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. |

Evidence is seen of residents/family being communicated with in an open and informative manner.

The service has a documented complaints management system which is implemented. There were no outstanding complaints at the time of audit. This was an area identified for improvement in the previous audit and this is now fully attained

## Organisational management

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| 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. |

San Michele has a business plan which covers service delivery planning. The business plan is reviewed annually to ensure residents’ needs are being met. All services are overseen by a business manager who has been in the role for 19 years and a nurse manager who oversees all clinical care and has been in the role for 14 years.

Policies and procedures are in place related to the current level of care offered. From a clinical perspective, they need to be strengthened to reflect the requirements of hospital-medical (non-acute) certification which has been applied for as part of this audit.

The service has quality and risk management systems which are understood by staff. Quality management reviews include an internal audit process, complaints management, resident and family/whānau satisfaction surveys, residents’ meetings, incident/accident, restraint and infection control data collection. Quality and risk management activities and results are shared at staff meetings. Corrective action planning occurs as required.

Good human resources practices are implemented. The staffing skills mix is appropriate for the level of care offered. Every shift is covered by a registered nurse who holds a current first aid certificate. Staff training content identifies that the service offers and seeks education related to the age care sector. Two areas identified for improvement in the previous audit are now fully attained. A new area identified for improvement relates to planning of education for 2016.

As confirmed during resident and family/whānau interviews, residents’ needs are met.

## Continuum of service delivery

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| 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. |

Services are provided by suitably qualified and skilled staff to meet the needs of residents. Timeframes for the development of long term care plans are met. When there are changes in the resident`s needs, a short term care plan is developed and implemented to reflect this. Evaluations occur six monthly on all aspects of the care plan. There is a multidisciplinary team approach to service delivery and continuity of care is promoted.

The residents’ files reviewed did not contain the required completed interRAI assessments. There are fewer than two registered nurses (RNs) who have completed the required training. This is an area that needs improvement.

The general practitioner reviews all residents medically at the required timeframes and more frequently as needed. Referral to other health and disability services is planned and coordinated, based on the individual needs of the resident.

The service has a planned activities programme to meet the social and recreational needs of the residents. Residents are encouraged to maintain links with family/whanau and the community.

A safe medication system was observed at the time of the audit. The staff responsible for medication management have completed annual competencies.

The residents` nutritional requirements are effectively met by the service with preferences and special diets being catered for appropriately. The service employs experienced staff who prepare the meals from a four week rotating summer/winter menu plan which has been approved by a registered dietitian.

## Safe and appropriate environment

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| 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 building has a current building warrant of fitness. There have been no changes made to the building footprint since the previous audit. Staff verbalised their knowledge related to emergency management. The last fire drill occurred on 26 November 2015. The facility has emergency supplies including a secure water supply should an emergency occur.

Four areas identified for improvement in the previous audit have been fully attained.

## Restraint minimisation and safe practice

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| 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. |

Policy describes enablers as being voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education planning process.

There are 10 restraints in use at the time of audit. Restraint episodes, including monitoring processes, are documented to meet the requirements of the Health and Disability Services standards. One area identified for improvement in the previous audit is now fully attained.

## Infection prevention and control

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

The infection control nurse/manager completes a monthly surveillance programme, where infections data is collated, analysed and trended and compared with previous data. Where any trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff monthly meetings. An external infection prevention and control service provides education and advice as needed.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **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 | 16 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 3 | 0 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **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. | FA | Complaints management is implemented to meet policy requirements. Complaints are kept together in a book with all the detail which allows for the process to be audited. The issue, the date received and the date the complaint was closed off are shown. There are no open complaints at the time of audit. The area identified for improvement in the previous audit is now fully attained.  The manager confirmed complaints management information is used as an opportunity to improve services as required. Complaints processes are explained during the admission process as confirmed during family/whānau interviews.  Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a standing agenda item for staff meetings. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The service promotes an environment that optimises communication and reflects residents’ rights to have full and frank sharing of information. Policies and procedures are in place if interpreter services are needed.  The family/whanau interviewed confirmed they are kept informed of any concerns or issues related to their relatives.  The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The cultural appropriateness procedure documents that residents and families who do not speak English shall be advised of the availability of an interpreter at the first point of contact with the service.  The service promotes an environment that optimises communication and staff education related to appropriate communication methods.  Family interviewed confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. Evidence of open disclosure is documented in the residents’ files reviewed, on the accident/incident form and in the residents` progress notes. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation’s mission statement and philosophy are documented in policy. The service has identified goals which are reviewed annually by the business manager who has full designated authority to oversee all nursing matters including, staff management, the purchase of supplies, organising medical contractors and employing junior staff without consultation with the director. Policy identifies that the quality programme in place ensures the timely supply of services which are fit for their designated purposes. Quality and risk processes are undertaken to mitigate known risks.  On the day of audit there were 22 hospital and six rest home level care residents.  The business manager has been in the role for 19 years and the nurse manager, who is a registered nurse, has worked at the facility for 14 years, 13 of these years as nurse manager. The job description for both roles identifies the authority, accountability and responsibility for each position.  Interviews with residents and family/whānau members confirmed that their needs were met by the service. |
| 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. | PA Low | Policies and procedures sighted have been reviewed by the business manager and clinical manager to reflect alignment with good practice and service delivery requirements. Legislative requirements are met. Policies and procedures need to be strengthened to better reflect non-aged care residents to gain hospital-medical (non-acute) certification.  Staff confirmed during interview that they understood and implemented the quality and risk management systems documented. These processes include regular internal audits, incident and accident reporting and analysis, health and safety monitoring, infection control management and data recording, restraint and complaints management processes. As confirmed in documentation and staff meeting minutes sighted, if an area of deficit is found corrective measures are put in place to address the situation on a summary of action sheet. Documentation of corrective actions was an area identified for improvement in the previous audit and is now fully attained.  The quality data results are reported at staff meetings and cover the key components of service delivery and corrective measures put in place are discussed and evaluated during staff meetings. Quality improvements are shared with residents and family/whanau as appropriate.  Actual and potential risks are identified and documented in a hazard register which covers all aspects of service provision. The business manager confirmed that hazards are reviewed at least annually. Staff confirmed that they understood and implemented documented hazard identification processes.  Residents and families/whānau interviewed confirmed they are happy with the services provided. Staff verbalised quality improvements which are now embedded into everyday practice. |
| 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 | Policy is in place to inform staff about how to manage adverse event reporting. The service records all incidents and accidents on specific forms. Any follow up required is put in place in a timely manner by either the business manager or the nurse manager. Staff interviewed confirmed they report and record all incidents and accidents.  Documentation confirms that information gathered from incidents and accidents is used as an opportunity to improve services where indicated. Incident and accident information is reported at staff monthly meetings as confirmed in minutes sighted.  Family/whānau members interviewed stated they are kept informed of any concerns the staff may have.  Discussions were undertaken with both members of management related to the correct use of section 31 reporting including pressure injuries. Forms were downloaded from the Ministry of Health website for the service. Management confirmed their understanding related to the obligations in relation to essential notification requirements. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Policies and procedures identify human resources management practices that reflect good employment practice and meet the requirements of legislation. These are implemented by the service. Job descriptions clearly describe staff responsibilities and accountabilities. Five staff files reviewed identify that staff have completed an orientation programme with specific competencies for their roles. Staff annual appraisals are up to date. The business manager reported that the nurse manager does not require an annual appraisal as they meet on a daily basis and share information.  Staff education is documented in each staff member’s file. The content of the education presented is listed on the back of most attendance sheets. This was an area identified for improvement in the previous audit and has been addressed by the service. There is no documented ongoing education calendar in place for 2016.  Nursing staff that require professional qualifications have them validated annually, as confirmed in documentation sighted. The business manager stated that she has implemented electronic checks of the GPs’ annual practising certificates to ensure they remain valid. It was suggested this process be documented for ease of auditing processes. This was an area identified for improvement in the previous audit and is now met.  Resident and family/whānau members interviewed identified that residents’ needs are met. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy related to staff skill mixes and experience is reflected in the roster and meets contractual requirements. There is a registered nurse on every shift.  A review of the roster showed that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed they have adequate staff on each shift to allow all tasks to be completed in a timely manner and that residents’ needs are met. This is supported by resident and families/whānau interviewed.  The nurse manager works Monday to Friday. There are dedicated kitchen and domestic and activities hours shown on the roster. |
| 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. | FA | The medication policies are accessible to guide staff as required. The sighted policies meet the legislative requirements and best practice guidelines. All medications are managed by the registered nurses. The NM and registered nurses have completed annual medication competencies. The caregivers have checking competencies.  Medicines are received from the contracted pharmacy in a pre-packed delivery system. The medications are checked by the registered nurse on duty. The medications are stored in the two lockable medication trollies available and stored in the clinic, when not in use. Controlled drugs are checked weekly and the register is maintained. A controlled sticker is used on each of the medications in the locked cupboard. A signature specimen list is now in the controlled drug register. There is a clear process for medication/incident events. The RN have received education from the hospice on ‘pain pump’ management.  A safe system for medicine management was observed on the day of the audit. The registered nurses only contact the GP with any queries or points of clarification as needed.  The medication records randomly selected and reviewed have been reviewed by the GP on a regular basis and records are maintained. All medicines are prescribed individually on the records reviewed. There is a staff signature specimen list maintained for all staff who administer medicines in the front of the medication record books in each area of service. Photographic identification is evident on all medication records. The medication signing records are completed by the pharmacist and as each medication is administered it is signed off by the registered nurse. Medication returns to the pharmacy are recorded and monitored and the date when returned to the pharmacy is documented. The previous area for improvement has been addressed.  Medication fridge storage is monitored. There is no resident’s self-medication and there are no standing orders at this facility. |
| 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 | Two professional cooks work seven shifts each over a fortnight (5.00am to 1.00pm). Two kitchen assistants work in the afternoons on a seven day roster/fortnightly. All kitchen staff are fully informed about food handling and practices to meet legislative requirements. The food safety management education undertaken is appropriate to service delivery. A menu audit was completed by a consultant registered dietitian and a letter sighted. The dietitian is available on a referral basis. The menu rotates and summer and winter menus are prepared.  Policies, procedures and guidelines are available that are current and up-to-date and include a separate cleaning schedule, temperature monitoring requirements, hygiene standards for staff, purchasing of food, checking deliveries, storage and waste management.  Regular monitoring and surveillance of the food preparation and hygiene is performed. The kitchen is well designed, clean and functional. A nutritional profile is completed as part of the admission process and this information is shared with the cooks to ensure all needs, wants, preferences and special diets/days are catered for.  Annual service surveys completed by residents/family include the food service. The families and residents interviewed reported satisfaction with the meal service.  All aspects of food procurement production, preparation, storage, delivery and disposal complies with current legislation and guidelines. There is evidence of fridge/freezer temperature recordings which meet food safety requirements. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | As observed during the audit and from review of the care plans, support and care was individualised and focused on achieving desired outcomes/goals set. The caregivers interviewed demonstrated appropriate skills and knowledge of the individual needs of residents. The records sighted showed evidence of consultation and involvement with the resident and family. The residents interviewed reported satisfaction with the care and services provided.  Short term care plans are developed as necessary for any event that is not part of the care plan, such as weight loss and wound/skin tears management. The registered nurses ensure the GP is kept well informed of progress.  The service has adequate stocks of wound and continence products to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the residents` needs being able to be met. Observations on the day of audit indicated residents are receiving care that is consistent with their needs. The registered nurses interviewed reported that all care plan interventions are accurate and kept up to date. Each registered nurse is allocated a number of residents to be responsible for from admission and in the longer term.  Evidence is seen in documentation of dietician, hospice, wound care and mental health services involvement as required. |
| 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 | The activities programme ensures resident’s individual motivational, recreational and cultural needs are recognised. Each resident is assessed on admission by an experienced diversional therapist. The residents have the opportunity to maintain interests, choices and activities in a continuing care environment. The diversional therapist discussed the activities programme and how it is developed and implemented. The programme sighted was based on the residents` needs, interests, skills and strengths and covers cognitive, physical and social needs.  The diversional therapist has been in the role for eleven years and attends quarterly networking meetings for support. She has completed some NZQA education papers and is continuing further papers part time.  The activities programme is planned monthly and displayed around the facility. Residents and families can access the information displayed. A resident meeting is held regularly and minutes of the meetings are maintained and were sighted.  The diversional therapist maintains attendance records of each resident`s participation. The activities staff are mindful that resident participation is voluntary and this is respected. One on one activities are arranged for the hospital level residents who are unable to attend the group sessions. Each resident has their own activities plan which is reviewed six monthly. The diversional therapist provides updates on each resident as part of the multidisciplinary team meeting.  Residents are encouraged to maintain links with the community and family. The service has access to a community wheelchair wagon for external activities and outings in the community. Special days are celebrated, for example birthdays, cultural days, anniversaries and other special events. Christian groups visit and church services are held weekly. Communion can be arranged.  Residents were seen visibly enjoying the activities seen during the audit and residents interviewed |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Service delivery plans, such as the care and activities plans, are reviewed six monthly or more often if required. Evaluations are resident focused and indicated the degree of achievement or response to supports/interventions and progress towards meeting the set goals. If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with the GP. Residents` changing needs are clearly described in the care plans reviewed. Short term care plans are instigated on the short term plan provided and are retained in a separate folder in each service area, medical and nursing notes and the resident`s progress notes.  The caregivers interviewed demonstrated good knowledge of short term care plans and reported that these are identified and information is shared in the handover book and handover between the shifts. Progress is also discussed as part of the six monthly multidisciplinary team reviews.  Families reported that they are consulted when staff have any concerns or when there are changes in the resident`s condition. This is documented on the family contact record sheet evidenced in all records reviewed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | Documentation identifies all processes are maintained for the facility’s current building warrant of fitness which expires in June 2016. There have been no changes made to the footprint of the building since the previous audit. The physical environment minimises risk to residents and promotes safe mobility. Oxygen cylinders are securely stored bathroom wall board allows area to be cleaned, and equipment is maintained. One toilet chair which showed areas of rust was removed on the day of audit. The areas identified for improvement in the previous audit have been addressed. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Cleaning and laundry chemicals sighted are securely stored. Washing powder is kept in the laundry with the door closed when it is not in use. The previous area for improvement has been addressed. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | Staff have undertaken updated education related to emergency management and can verbalise actions to be taken in case of an emergency occurring. The last fire drill was undertaken on 26 November 2016 and no corrective actions were noted.  There are emergency supplies stored at the facility. There is a BBQ available. The service has had an outdoor water supply tank installed to ensure there is enough water should an emergency occur.  The two areas identified for improvement in the previous audit and are now fully attained. |
| 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 | The infection prevention and control surveillance that is undertaken is appropriate to the size and complexity of the service as shown in the infection control programme. All staff are required to take responsibility for surveillance activities as shown in the policy reviewed. An infection form is completed as soon as signs and symptoms have been identified and given to the ICN. Monitoring is described in the infection control plan to describe actions taken to ensure residents` safety.  The nurse manager completes the monthly infection surveillance report. Monitoring occurs for all urinary infections (UTIs), eye infections, upper respiratory and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections. The monthly analysis of the infections includes comparison with the previous month, reasons for the increase or decrease of infections and actions taken to reduce infections. The analysis includes a summary that can be fed back to staff at the staff meetings. Graphs are available as a visual methodology which staff can relate to and these are displayed for staff on the staff notice board. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policy clearly describes enablers as voluntary and the least restrictive option to meet residents’ needs. The facility has ten restraints in use at the time of audit. None of the restraints in use are enablers. Interviews with staff confirm their understanding of restraint verses enablers and the actions to be taken when either are in use. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | Monitoring is undertaken and documented for restraint to meet residents’ assessed needs. Dates, times and frequency of restraint use is clearly shown. This is confirmed in resident file reviews. Staff verbalised their knowledge and understanding of safe restraint use and the monitoring processes and frequency that must occur when restraint is in use. This was an area identified for improvement in the previous audit and is now fully attained. |

# 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.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.3.3  The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | Policies and procedures sighted are aligned with current good practice and service delivery to meet legislative requirements for rest home and hospital level care aged care services.  Policies need to be reviewed and strengthened related to medical care (non-acute) services. | No specific polies were sighted at the time of audit related to hospital-medical care (non-acute) services. Whilst much of what is shown for aged care services relates to the request for additional medical service certification, these need to be made more specific for non-aged care residents. | Provide evidence of policies and procedures to better reflect hospital-medical (non-acute) certification requirements.  180 days |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | Staff were observed providing appropriate safe, effective services. Staff attendance is recorded for education undertaken. The content of the education is documented on the back of most attendance forms. This was an area identified for improvement in the previous audit and is now met. The education presented is related to the service provided. However, no educational planning for 2016 has been undertaken to date. The staff meeting minutes and staff interviews confirmed that they have been asked for their input into what education they would like and if there are any special issues they want covered. The nurse manager stated that she has not yet had time to compile an education calendar. There was one lot of education conducted in 2016 related to manual handling.  Staff confirmed the education they have received covers all aspects of care including special needs items, such as syringe driver training, percutaneous endoscopic gastrostomy (PEG) feeding education, wound care and palliative care. | No staff education planning for 2016 has been undertaken to date. | Provide evidence that ongoing education for service providers is documented and planned.  180 days |
| Criterion 1.3.3.1  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. | PA Low | There is an area for improvement relating to interRAI assessments and interRAI trained staff | Residents files reviewed did not contain relevant interRAI assessments and there are not the required number of staff interRAI trained to ensure assessments are completed. | Provide evidence that all residents are interRAI assessment to meet HealthCert requirements.  Timeframe (days): 180  180 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.