# Oceania Care Company Limited - Wharerangi Care Centre

## 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 Central Region's Technical Advisory Services 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:** Oceania Care Company Limited

**Premises audited:** Wharerangi Rest Home and Village

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

**Dates of audit:** Start date: 16 May 2016 End date: 17 May 2016

**Proposed changes to current services (if any):** Reconfigure the certified services by increasing dual purpose beds by seven from 27 to 34. This to be achieved by reducing dementia beds from 20 to 13 and will mean no change in the total bed number of 47. Both the dual purpose (hospital/rest home) and dementia unit will have nurses stations positioned within them.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 46

# 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** |
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|  | 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

Wharerangi Rest Home and Village (Oceania Care Company Limited) can provide care for up to 47 residents requiring care at either rest home, dementia or hospital level with 46 residents on the day of audit. The reconfiguration of the beds to decrease the number of beds at dementia level and increasing these as dual purpose beds has been achieved with services provided that meet resident needs.

This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

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

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and the regional and executive management team. Service delivery is monitored.

Requirements identified at the previous audit around the quality and risk management programme, human resources and documentation of clinical care have been addressed.

## 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. |

Staff interviewed are able to demonstrate an understanding of residents' rights and obligations including the complaints process. Information regarding the complaints process is available to residents and their family. Complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident with this recorded in the residents’ files. Residents and family state that the environment is conducive to communication including identification of any issues.

## 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. |  | Standards applicable to this service fully attained. |

Wharerangi Rest Home and Village have documentation of the Oceania quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and the business status reports allow for the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented. Corrective action plans are documented with evidence of resolution of issues.

Staffing levels are adequate across the service with human resource policies implemented. This includes evidence of recruitment and staffing. Rosters indicate that staff are replaced when on leave.

## 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. |  | Standards applicable to this service fully attained. |

Residents receive services from suitably qualified and experienced staff. Care plan evaluations are documented, resident focused and indicate progress towards meeting residents’ desired outcomes. Where progress of a resident is different from expected, the service responds by initiating changes to the long term care plan. Short term problems are recorded on short term care plans. Family have opportunity to contribute to care planning and care plan reviews.

Recreational assessment and recreational plans are completed for residents. Activities are planned and there is evidence of input to the activities programme by a diversional therapist. The activities programme is available to residents throughout the service. Residents in the dementia unit have challenging behaviour plans to manage their behaviour over 24 hours.

The medication management system evidences processes for reconciliation, prescribing, administration, dispensing, storage and disposal of medicines. Medicine management training is conducted. There is one resident in the rest home that self-administers medicines. Self-administration of medicines is congruent with legislative requirements. All staff responsible for medicines management have current medication competencies.

Food and nutritional needs of residents are provided in line with recognised nutritional guidelines and menus are reviewed by a dietitian. Food service complies with current legislation and guidelines.

## 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. |

There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate with indoor and outdoor areas that meet their needs. There is a secure dementia unit that includes indoor and outdoor areas.

## 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. |

Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. There were two residents using restraint and no residents requiring enablers on audit days. Staff education in restraint, de-escalation and challenging behaviour has been provided.

## 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. |

Surveillance of infections is occurring according to the providers policies which suits their size and service type. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance and benchmarked against other Oceania facilities.

## 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 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 0 | 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 | The organisation’s complaints policy and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes periods for responding to a complaint. Complaints forms are available in the facility.  A complaints register is in place and the register includes: the date the complaint was received; the source of the complaint; a description of the complaint; the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaints folder. There have not been any complaints in 2016. Two complaints lodged in 2015 were tracked and these indicate that all timeframes are met, as per policy, when responding to the complaints.  Residents and family members interviewed all state that they would feel comfortable complaining.  There have been no complaints forwarded by the Health and Disability Commission or any other external agency since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.  If the resident has an incident, accident, a change in health or a change in needs, then family are informed as confirmed in a review of accident/incident forms and documentation in the resident files.  Resident files reviewed include documentation around family contact. Interviews with family members confirm they are kept informed. Family confirm that they are invited at least six monthly to the care planning meetings for their family member.  Interpreting services are available, when required, from the district health board. The business and care manager states that families are involved in resident care and can interpret, when required. There were no residents requiring interpreting services at the time of the audit. All residents interviewed confirm that staff are approachable and communicate in a way that meets their needs. The business and care manager has an open door policy that allows residents, family and staff to communicate any issues at any time. There are also resident and family meetings with minutes reviewed indicating that residents and family can discuss issues.  An information pack is available in large print and staff interviewed advised that this could be read to residents.  Staff training records include training around connecting with people and communication. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Wharerangi Rest Home and Village is part of the Oceania Care Company Limited with the executive management team including the chief executive officer and general manager, regional operational manager and clinical and quality manager who provided support to the service on the days of the audit. Communication between the clinical and quality manager, the regional operations manager and the business and care manager takes place on a regular basis (at least once every six weeks) with more support provided, as required.  Oceania has a clear mission, values and goals and staff interviewed are able to describe these. These are displayed in the service.  The facility can provide care for up to 47 residents requiring rest home, dementia or hospital level of care. At the time of the audit, there are 34 dual purpose beds (hospital or rest home level of care) and 13 dementia level beds. The audit confirms that Wharerangi Rest Home and Village has reconfigured the number of dementia beds by reducing the number from 20 at the previous audit to 13 and increasing the number of dual purpose beds from 27 to 34. There is no change to the role of the clinical manager or business and care manager required. The clinical manager is able to describe allocation of staffing to acuity of residents.  During the audit, the occupancy was at 46 with 12 residents in the dementia unit, 22 residents requiring rest home level care and 12 residents requiring hospital level care. There were no residents aged less than 65 years of age.  The business and care manager has been with the service for eight years with eighteen months in the current role. The business and care manager has a certificate in business management. The clinical manager (registered nurse) provides clinical oversight of the service and has been in the role for two years. |
| 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 | Wharerangi Rest Home and Village use the Oceania quality and risk management framework that is documented to guide practice. The business plan is documented and reporting occurs through the business status reports and a monthly summary completed by the business and care manager and clinical manager. This includes financial monitoring, review of staff costs, progress against the healthy workplace action plan, review of complaints, incident and relationships.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews, as required, with all policies current. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based and best practice guidelines. Policies are readily available to staff and new and revised policies are signed by staff to say that they have read and understand them. The policy around pressure injuries has been reviewed in 2016 and has been read by all staff as confirmed by the business and care manager interviewed.  Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of an internal audit programme. Quality improvement data is analysed through meetings and benchmarking. Corrective action plans are documented with evidence of analysis, discussion of data and documentation of evidence of resolution of issues. This includes resolution of issues identified at meetings, in satisfaction surveys with a report documented and in results from internal audits. The improvement required at the previous audit has been met.  There are monthly meetings with minutes documented that include the following: management; health and safety; staff; quality; registered nurse; infection control. There are separate resident and family meetings bi-monthly (alternating months). The resident and family meetings have been held regularly as per meeting minutes reviewed from July 2015 and 2016 to date. The improvement required at the previous audit has been met. All staff interviewed report that they are kept informed of quality improvements and are able to have input into the quality programme.  The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service and there is an annual health and safety plan implemented and monitored. There is a documented hazard management programme and a hazard register for each part of the service. Any hazards identified are signed off as addressed or risks are minimised or isolated. Staff have training and support around management of residents with challenging behaviours and there is a meeting held with the business and care manager and relevant staff in the dementia unit on a three monthly basis to provide support, training and opportunities for discussion of any issues. Staff state that this helps to minimise risks for staff working in the dementia unit.  There is a six monthly satisfaction survey for residents and family. The survey completed in February 2016 indicates that residents and family are satisfied with the service overall. The resident and family meetings held in March and April 2016 confirm that the satisfaction survey report has been tabled with any opportunities for improvement discussed. The improvement required at the previous audit has been met. |
| 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 business and care manager and the clinical manager are aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; sentinel events around pressure injuries; critical incidents and infectious disease outbreaks. Times when authorities have had to be notified would be documented and retained on the relevant file.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff records reviewed demonstrate that staff receive education at orientation on the incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events.  Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania facilities.  The clinical manager reviews all incidents and documents strategies to manage clinical care with the business and care manager reviewing and signing off all incident forms. |
| 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. | FA | Human resource policy and processes are in place. All registered nurses (RN) hold current annual practising certificates. Current visiting practitioners’ practising certificates reviewed are current and include: the general practitioners; pharmacists; dietitian; podiatrist and physiotherapist. Staff files include employment documentation such as: job descriptions; contracts and appointment documentation on file. Criminal vetting is completed and an annual appraisal process is in place with all staff files reviewed having a current performance appraisal on file. References are documented as being completed for new staff. The improvements required at the previous audit around criminal vetting, performance appraisal for the clinical manager and reference checking have been met.  A comprehensive orientation programme is available for staff. Staff files show completion of orientation. Staff are able to articulate the buddy system in place and the competency sign off process completed. The clinical manager has completed an orientation with evidence of this documented. The improvement required at the previous audit has been met.  Mandatory training is identified on a training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training held. Staff receive annual training that includes attendance at training sessions and annual individualised training around core topics such as: medication; restraint; infection control; health and safety; manual handling and continence. RNs receive training from the district health board that includes relevant topics such as: pain management; wound management; nutrition; medication administration and falls. There are four RNs trained to complete interRAI assessments, including the clinical manager. The training register and training attendance sheets show staff completion of annual medication and other competencies such as: hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin.  Staff have completed training around pressure injuries (PI) in 2015 and 2016. This includes specific in-depth training around wound management and dressings for registered nurses including training around PIs and identification and monitoring of PIs for other care staff. The service has moved to having a day a year training for health care assistants and the plan continues to include training around incontinences products and prevention of PIs.  Ten health care assistants working in the dementia unit have completed training around dementia and all others are currently enrolled in training around supporting residents with dementia. Education and training hours exceed eight hours a year for all staff reviewed. The health care assistants state that they value the training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy. Rosters indicate that residents requiring either dementia, hospital or rest home level of care are supported by an adequate number of staff on duty at any given time.  Residents and families interviewed confirm that staffing is adequate to meet the residents’ needs during the weekdays. The same staffing model is applied at weekends.  There were 42 staff at the time of the audit, including the business and care manager and the clinical manager. Household staff are appointed and include cleaners, laundry and kitchen staff who provide services seven days a week. An activities coordinator facilitates activities five days a week in all areas with staff providing activities at other times. There are six RNs employed in the service with a RN on duty at all times.  Staff are allocated specifically to the dementia unit. There is a senior health care assistant who provides oversight for care in the dementia unit with support from the clinical manager and RNs. There is at least one health care assistant on duty in the dementia unit with two health care assistants in the morning and over dinner and bedtime in the evening. Staff in the dementia unit are able to call other staff through a pendant alarm carried by staff in the dementia unit with this lighting up on the callboard in the rest home/hospital area. Staff in the dementia unit state that if they call, staff respond immediately.  Staffing has been adjusted to reflect the change in numbers of residents both in the dementia unit and for residents occupying the dual purpose beds with extra staff added to both morning and afternoon shifts. Staff specifically state that they are aware of the layout of the building and response to needs of residents in all areas of the facility with particular reference to residents requiring more care in the rooms now identified as being dual purpose beds (initially dementia level care beds).  The business and care manager and clinical manager are on call after hours. A senior RN or a clinical manager from a neighbouring facility is on call if the clinical manager is on leave. |
| 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 | Medication areas, including controlled drug storage, evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained. The registered nurses and the clinical manager complete weekly checks and six monthly physical stocktakes are completed by a pharmacist from the local pharmacy. The medication fridge temperatures are conducted and recorded weekly.  Current medication competencies for staff who administer medicines were sighted. The medication round was observed during lunch time. The staff member was knowledgeable about how to identify the appropriate resident, checking the medicines against the script/administration sheet, appropriate communication with the resident, administration and sign off at the end of the process. Administration records and specimen signatures are maintained.  There was one resident in the rest home self-administering medicines and this was conducted, according to policy. Three monthly medicines reviews were conducted for the residents within the required timeframes. Medication audits have been conducted and corrective actions are implemented following the audits. |
| 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 | Interview with the cook confirmed kitchen staff have completed food safety training, and this was verified by food safety certificates. Interview with the cook confirmed they were aware of the residents’ individual dietary and nutritional needs. The residents' files demonstrate monthly monitoring of individual resident's weight. Interviews with residents confirmed they are satisfied with the food services and reported their individual preferences are met and adequate food and fluids are provided.  On inspection, the kitchen environment was clean, well-lit and uncluttered. There was evidence of kitchen cleaning schedules, signed off as cleaning is completed. Fridge, chiller and freezer temperatures as well as food temperatures are monitored regularly and recorded.  There is a seasonal menu, last reviewed by a dietitian in April 2016. Review of residents’ files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals are available along with alternative nutrition appropriate to the residents.. There was enough stock to last for three days, feeding all residents in an emergency situation. Food services are discussed during resident meetings. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The residents' person centred care plans (PCCP) evidence the required interventions, desired outcomes or goals of the residents. The GP documentation and records are current. Interviews with residents and family confirm their and their relatives’ care and treatments meet their needs. Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained. Interviews with staff confirmed they are familiar with the current needs and required interventions of the resident they were caring for. Handover attendance confirmed staff members being aware of the specific needs of the residents they care for on the specific shift. |
| 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 service employs one activity coordinator who receives input and has oversight from a diversional therapist (DT). The DT, from another site, oversees the residents’ activity programmes. Interview with staff responsible for activities (health care assistants help out with the implementation of the programmes in the different areas of service delivery), confirmed the activities programme is available to all residents in the hospital, rest home and the dementia unit. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations.  There are activities assessments and activities care plans in residents’ files reviewed. Activities care plans in the residents’ files reviewed had intervention relating to the activities goals. The residents’ activities attendance records are maintained as are activities progress notes. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Interviews with residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. Residents’ progress records are entered on each shift. When resident’s progress is different than expected, the RN contacts the GP, as required. Short term care plans were sighted in some of the residents’ files, and these are used when required. The family are notified of any changes in resident's condition, confirmed at family interviews. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, as required.  The previous requirements for improvement relating to the person centred care plans not reflecting the degree of achievement in the review of care plans are fully implemented. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date at the end of May 2016 with a new building warrant of fitness being processed).  Previously, the dementia unit was a secure unit for 20 residents. The number of beds in the dementia unit has been reduced to 13 with the swipe card access re-enabled on the internal doors between the dementia unit and the dual purpose beds. The dual purpose beds have been increased from 27 to 34 with all accommodating equipment and staff required to support residents requiring either hospital or rest home level care. The dual purpose bedrooms have a width of one and a half doors to allow easy access into the rooms. The nurse’s station in the rest home/hospital area is centrally situated and there is a separate nurse’s station in the dementia unit.  A planned maintenance schedule is implemented and both the maintenance staff and documentation confirmed implementation of this. There is also reactive maintenance with the maintenance staff prioritising any issues daily. There is evidence documented of resolution of any maintenance issues.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There is a separate lounge and dining area for residents in the dementia unit and a secure outdoor area that encourages residents to engage in activities.  Equipment relevant to care needs is available and staff confirm this is sufficient. A test and tag programme is in place. Equipment is calibrated.  There are safe external areas for residents and family to meet/use and these include paths, seating and shade. |
| 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 | Documentation review provided evidence that the surveillance reporting processes are applicable to the size and complexity of the organisation. Surveillance is aligned with the organisation’s policies. Infections are recorded as quality indicators on the intranet.  Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on monthly at staff, quality, and infection control and health and safety meetings. Interviews confirmed information relating to infections is made available for clinical staff during hand over and at staff meetings.  The infection control coordinator (RN) is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at staff meetings. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. This was evidenced during attendance at the staff handover and review of the residents’ files.  In interview, the ICC confirmed no outbreak had occurred at the facility since last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler use at the facility is congruent with the definition in the standard. There is a job description for the position of the restraint coordinator. The restraint coordinator is the clinical manager. There were two restraints and no enablers being used in the facility on audit days. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded and reviewed. Restraint and enabler use are documented in residents’ care plans and up to date. |

# 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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| No data to display |

# Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.