St Clair Park Residential Centre Limited - St Clair Park Residential Centre

Introduction

This report records the results of a Certification 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	St Clair Park Residential Centre Limited
Premises audited:	St Clair Park Residential Centre
Services audited:	Rest home care (excluding dementia care); Residential disability services - Psychiatric; Residential disability services – Sensory
Dates of audit:	Start date: 13 July 2016 End date: 14 July 2016

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 26

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

St Clair Residential Park is privately owned. The service is certified to provide rest home and residential disability (psychiatric and sensory) level care for up to 35 residents. On the day of the audit there were 26 residents. Since the last audit the service has ceased providing residential disability (physical and intellectual) level of care.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, staff and management.

St Clair is managed by a manager with experience managing student halls and has been in the role since November 2015. He is supported by a clinical leader with aged care and mental health experience. Feedback from residents was positive about the care and services provided. An induction and in-service training programme is provided.

Improvements are required around meeting minutes, corrective action planning, health and safety documentation, family participation for mental health, human resources management, staff training, documenting designations in progress notes, timeliness of documentation, evaluations, annual review of the infection control programme and some infection control practices.

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.

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to residents and families. Cultural diversity is respected. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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 medium or high risk and/or unattained and of low risk.

Services are planned, coordinated and are appropriate to the needs of the residents. The manager and clinical leader are responsible for the day-to-day operations of the facility with the support of an assistant manager. Business goals are documented for the service with evidence of quarterly reviews.

An annual resident/relative satisfaction survey is completed and there are regular resident meetings and resident/management meetings. There are policies to support consumer and family involvement at all levels of the service. Staff have received regular training.

Registered nursing cover is provided eight hours per day, five days per week by two registered nurses who alternate on-call duties.

The residents' files are appropriate to the service type.

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.

Entry to the service is managed by the manager and the clinical leader. There is comprehensive service information available. Assessments, strengths assessments, support plans, crisis management and recovery plans are completed by a registered nurse. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. A general practitioner and/or a psychiatrist reviews residents at least three monthly or more frequently if needed. Meals are prepared off-site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents interviewed were complimentary about the food service.

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.

There are documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. The building has a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with access to communal facilities. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services.

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.

St Clair Park has a no restraint policy in place. Staff receive training in restraint minimisation and challenging behaviour management. The service maintains a restraint free environment and no enablers were in use.

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

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. Documentation evidences that relevant infection control education is provided to all service providers as part of their orientation and also as part of the ongoing in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	40	0	6	2	0	0
Criteria	0	105	0	11	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service (link 1.2.7.4), which continues through in-service education and training. Interviews with staff (three support workers, the assistant manager/activities coordinator, the clinical leader and the registered nurse) reflected their understanding of the key principles of the Code.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Rest home and mental health: Informed consent processes are discussed with residents and families on admission. Six resident files sampled (two mental health, two rest home, one chronic health condition and one ACC contract) evidenced that written consents are signed by the resident or EPOA. Advanced directives are signed for separately. There is evidence of discussion with the general practitioner and resident when completing resuscitation orders. Support workers and the registered nurse interviewed confirmed verbal consent is obtained when delivering care. A review of files evidences documentation of discussion and involvement of family members regarding decisions that affect their relative's lives. Resident files reviewed include signed admission agreement. Residents interviewed indicated they make informed choices and give consent to care provided.

		St Clair Park ensures that residents are provided with written informed consent for treatment, intervention and/or support and are offered a copy of their recovery plan (MHA 24). Advised by the registered nurses that most residents decline a copy of their recovery plan.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC Office is included in the resident information pack that is provided to residents and their family (if present) on admission. Pamphlets on advocacy services are available at the entrance to the facility and located around the facility. Interviews with the residents confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do. This includes resident's visits to the local mall, visiting the library and attending community groups. Resident meetings are held monthly.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the manager using a complaints' register. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner. Discussions with the residents confirmed they were provided with information on complaints and complaints forms. All complaints from 2015 and 2016 were reviewed with evidence of appropriate follow-up actions taken.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The clinical manager/registered nurse (RN) discusses aspects of the Code with residents and their family (if present) on admission. Discussions relating to the residents' rights are held during the monthly resident meetings. All seven residents (three aged care and four mental health) interviewed by the consumer auditor reported that the

		residents' rights are being upheld by the service. Interviews with residents also confirmed their understanding of the Code and its application to aged residential care. No family members were available to be interviewed during the audit.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The service ensures that the residents' rights to privacy and dignity are recognised and respected at all times. The residents' personal belongings are used to decorate their rooms. Residents all have single rooms. Discussions of a private nature are held in the residents' rooms. The support workers interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They report that they encourage the residents' independence by encouraging them to be as active as possible. All of the residents interviewed confirmed that their privacy is being respected. Guidelines on abuse and neglect are documented in policy. Staff have not received recent education and training on abuse and neglect (link 1.2 7 5). Any suspected instances of abuse or neglect are dealt with in a prompt manner by the management team.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. Cultural needs are document in relevant plans. Māori consultation is available through the documented iwi links. Staff have not received recent education around cultural awareness (link 1.2 7 5). All support workers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.
Standard 1.1.5: Recognition Of Pacific Values And Beliefs Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Pacific residents are valued and fostered within the service. During this audit there were no residents who identified as Pacific living at the facility. Staff have not received recent education on cultural awareness (link 1.2 7 5). All support workers interviewed were aware of the importance of the relationships between the Pacific consumer, their family and their community in the delivery of care for Pacific residents. The manager described links with Pacific representatives.

Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family (if available) and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' plans. All residents interviewed confirmed they were involved in developing their plan of care, which included the identification of individual values and beliefs. All plans reviewed included the resident's social, spiritual, cultural and recreational needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	A staff code of conduct is discussed during the new employee's induction to the service (link 1.2.7.4) and is signed by the new employee. Professional boundaries are defined in job descriptions (link 1.2.7.3). Interviews with support workers confirmed their understanding of professional boundaries including the boundaries of the support workers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is an infringement with the person concerned.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Good practice is promoted within the provision to service to the complex and diverse resident group. Registered nursing staff are available seven days a week. A general practitioner (GP) visits the facility weekly and an after-hours GP service is in place. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits for those residents whose condition is not deemed stable. There is a close link with psychiatric district nurses and psychiatrists. The service receives support from the district health board which includes visits from the mental health team and nurse specialist's visits. Physiotherapy and dietitian services are accessed from the district health board if required. There is a regular in-service education and training programme for staff (link 1.2.7.5) and nine support workers are completing a mental health support programme. The service has links with the local community and encourages residents to remain independent. The GP interviewed was satisfied with the level of care that is being provided.
Standard 1.1.9: Communication Service providers communicate effectively with	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file (where the resident has identified family or next of kin).

consumers and provide an environment conducive to effective communication.		Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms reviewed identified family are kept informed when appropriate. An interpreter policy and contact details of available interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. Aged Care Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement (it is noted that there were no privately funded residents at the time of the audit).
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	St Clair Rest Home and Hospital is privately owned. The service currently provides care for up to 35 residents at rest home and psychiatric disability (psychiatric and sensory) levels of care. On the day of the audit there were 26 residents. Fourteen were funded under the MHA 24 mental health contract and nine under the age related care contract at rest home level care. Two residents were funded under long term chronic conditions contracts and one by ACC (physical disability). There were no residents receiving residential disability (sensory) level of care. A vision, mission statement and objectives are in place. Annual goals for the facility have been determined in the current business plan. The manager has been in the position since November 2015 and was new to the industry. Since commencing in the role, the manager has received mentorship from an aged care manager, has completed health and safety training and a one day Age Concern course. The manager has also completed interRAI for managers training as well as in-service training held at the facility. He is supported by the clinical leader who is a registered nurse with aged care experience, who is being mentored by an experienced mental health nurse.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner	FA	In the absence of the manager, the assistant manager who has worked at the service for in excess of 10 years, takes over operational responsibilities with support from the clinical leader.

which ensures the provision of timely, appropriate, and safe services to consumers.		
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 Moderate	There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and procedures relate to the different types of service provided and have been updated to meet current health and safety legislation or interRAI requirements. The quality plan is current and meets the requirements of the MHA 24 contract. A document control system is in place. Policies are regularly reviewed. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to): residents' falls, behaviour incidents, infection rates, complaints received and medication errors. However, these are not discussed in staff meetings and infection control meetings are not recorded. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are not always documented when service shortfalls are identified and signed off when completed. Falls prevention strategies are in place. A health and safety system is in place. Hazard identification forms and a hazard register are in place. The health and safety representative has recently completed training and completes annual environmental checks. The hazard register is not current and health and safety is not discussed in staff meetings or quality meetings. Staff have not received recent training in health and safety (link 1.2.7.5). This is planned for 22 July 2016.
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	Individual reports are completed for each incident/accident with immediate action noted and any follow up action(s) required. Incident/accident data is linked to the quality and risk management programme and discussed in quality meetings (link 1.2.3.6). Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow up by a registered nurse. Incidents are analysed for trends. The manager is aware of their requirement to notify relevant authorities in relation to essential notifications. Appropriate notifications were made around management changes.
Standard 1.2.5: Consumer Participation Consumers are involved in the planning, implementation, and	FA	St Clair has a policy that describes the ways in which residents can participate in the service. There is a regular residents meeting which allows all residents to have input into the service. Additionally, a representative group of mental health consumers meet regularly with the manager for minuted meetings to ensure resident's perspectives are included at all levels of the service. The manager and clinical leader also operate an open door policy. Residents' meeting terms of reference are outlined in policy. An annual

evaluation at all levels of the service to ensure services are responsive to the needs of individuals.		resident and a relative satisfaction survey is completed.
Standard 1.2.6: Family/Whānau Participation Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.	PA Low	St Clair Park has a family participation policy that includes terms of reference for families who choose to be involved in an advisory capacity. Relatives are also invited to complete an annual satisfaction survey and there is regular contact from the service to families around resident updates. In practice, most relatives do not have close involvement with the resident or the service. The family participation processes described in policy are not implemented.
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 Moderate	There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files sampled (the clinical leader, the registered nurse, the assistant manager/activities coordinator, a cleaner and four support workers) included evidence of employment contracts. Not all had current job descriptions, performance appraisals or evidence of reference checks. The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. documentation in staff files does not evidence all staff completing a documented orientation. Staff interviewed stated that new staff are adequately orientated to the service. A register of practising certificates is maintained. There is an annual education and training schedule but not all required training has been completed in the past two years. Records of attendance had not been kept until the two most recent trainings. The clinical leader is planning to commence post graduate mental health training in 2017. An experienced mental health nurse provides mentoring and oversight of the documentation and practice of the clinical leader and registered nurse, visiting the site at least weekly. Nine support workers are currently undertaking the Careerforce Mental Health and Addiction Support course with two having completed and one nearing completion (MHA 24).
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service	FA	The staffing levels meet contractual requirements. The clinical leader has 4 ½ years' experience in both aged care and mental health (MHA 24). The registered nurse has a scope of practice limited to general and obstetric nursing. The practice and documentation of both is supported by an experienced mental health nurse in a mentor role. All residents (aged care and mental health) have an identified support

from suitably qualified/skilled and/or experienced service providers.		worker as their key worker and this role includes one to one activities and outings (MHA 24). One of the registered nurses is on call at all times and both work 40 hours, Monday to Friday. There are five support workers on morning shift, three on afternoon shift and two on night shift, in addition to the assistant manager/activities coordinator. Interviews with the residents and support workers confirmed staffing overall was satisfactory.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	PA Low	The residents' files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas. Residents' files demonstrate service integration. Entries sighted were legible, timed, dated and signed by the relevant support worker or nurse but did not always include designation.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Rest home: The service has admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The manager and clinical leader (registered nurse) screen all potential residents prior to entry and records all admission enquiries. Two rest home residents interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. Mental Health: Access processes and entry criteria are outlined in policy. All referrals are made by the mental health service and discussed on an individual basis with the manager and clinical leader to ascertain suitability. Residents come for an initial visit where possible, usually with family and the case manager. All potential residents have a needs assessment completed by the service coordination service prior to referral. Each new or prospective resident is given an information pack that is part of the admission agreement. The resident information includes information around the Code of Rights, health and disability advocates, information on how to make a complaint and consent form.

Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Rest home: There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition as evidenced in the sample of files reviewed. The registered nurses provided an example of when a resident was reassessed using the interRAI assessment tool and transferred to a higher level of care. MHA 24: Discharge planning includes the following: 1. Involvement of residents and with their consent, this is communicated to all relevant support people. 2. Reassessment of risk, the relapse prevention plan and follow-up arrangements. 3. Advance directives. 4. Identifies medication on discharge and education about this. 5. Identification of relevant cultural needs. 6. Reference to psychosocial support needs. 7. Reference to: a) support needs, b) pre-vocational, and c) educational needs The service facilitates a planned exit, discharge or transfer of residents that is documented, communicated and effectively implemented. A discharge summary is given to the resident and where relevant, the general practitioner/primary care provider and support people. The registered nurses provided an example where a resident was discharged from the service, to reside in a supported living environment in the community.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	All service levels: The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Not all medication signing sheets evidence that medication prescribed is signed for correctly in the sample of 12 medication records reviewed. The support workers administer medicines. Staff that administer medication have been assessed as competent. The facility uses a blister pack medication management system for the packaging of all tablets. The registered nurses reconcile the delivery and document this. Medication charts are written by the GP and there was evidence of three-monthly reviews. Medications are prescribed and charted in line with guidelines. There are no residents

		who self-administer medications.
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	All food is prepared and cooked off-site by an external contractor and delivered in hot boxes at meal times. It is then transferred into bain maries and temperature checked before being served by support workers. A dietitian reviews all menus for a contracted company. Staff have completed basic nutrition and food safety training as sighted in training records. Special diets and likes and dislikes are catered to as reported by staff and residents interviewed. Changes suggested/requested by residents are faxed to the kitchen and the menu altered accordingly as reported by the activities coordinator and residents interviewed. Meals are appropriate to the client group, with individual meals supplied that cater to likes and dislikes and nutritional requirements. Breakfast is served as residents are ready for it. There is a wide variety of fresh fruit and snacks available for residents. Morning and afternoon teas are delivered with the main meals. Fridge, freezer and hot water temperatures are monitored in all three units with records sighted and temperatures noted to be within safe ranges. A recent meal satisfaction survey identified satisfaction with meals. Food and meals are discussed at resident meetings.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	Rest home: The service records the reason for declining service entry to residents should this occur and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Mental health: Residents have not been declined unless there is a lack of suitable placements, although residents may decide not to come to the service after the initial tour. They are then referred back to the needs assessment service. All declined entries are discussed with referrers.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All service levels: In six of six files sampled all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate risk assessment tools were also completed in two rest home resident files reviewed. Each resident in the sample has a momentum long-term care plan and a wellness recovery plan. Care plans reflect assessments. Strengths assessments have been completed for all residents with goals and a plan developed. These have been reviewed three monthly. Cultural assessments are completed as part of the interRAI assessment tool. MHA 24: The interRAI assessment and the strengths assessment is used in the development of an initial recovery plan. These assessments include treatment, intervention or support options, appropriate risk

		assessment/management and the plan for discharge, where appropriate. For the majority of residents, discharge is not planned for as the residents are long-term clients.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	All service levels: The long-term care plans reviewed described areas of the support required to meet the resident's goals and needs and identified allied health involvement under a range of template headings. All resident files sampled evidenced an initial care plan. Six long-term care plans were reviewed and were based on the interRAI assessment. Each of the six residents in the sample have a wellness recovery plan. The strengths assessment identified specific goals for the resident. Three monthly reviews of the strengths assessment and personal goals have been completed with the resident, key support worker, the clinical leader and the activities coordinator. Support plans include identification of early warning signs, relapse prevention and crisis intervention plans. Residents and their family/whānau are documented as involved in the care planning and review process. Short-term care plans are in use for changes in health status. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	All service levels: Support workers follow the care plan and report progress against the care plan at least daily. If external nursing or allied health advice is required, the clinical leader or registered nurse will initiate a referral (e.g., to the psychiatric district nursing service). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (e.g., dressings). Sufficient continence products are also available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described. There was wound documentation in place for one skin tear. There were no pressure injuries on the day of audit. Wound documentation includes assessments, management plans, progress and evaluations. The RNs have access to specialist nursing wound care management advice through the district nursing service. MHA 24: Recovery/support plans reviewed identify the support staff involved in the resident's care included the key support worker, psychiatric district nurses and psychiatrist. Assistance and support is sought for matters relating to personal, clinical, cultural, spiritual and social domains. All residents at St Clair Park have diagnoses of mental health conditions and all receive services that promote independence, are supportive and tailored to their individual needs. MHA24: Planned and time-limited support services/responses, based upon regular support needs assessment that informs a recovery/support plan are designed to meet the person's individual needs. This then reduces their need to utilise more intensive mental health services. The support services available are inclusive of the person's cultural needs and contribute to meaningful, positive changes in the resident's life

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	All service levels: An activities coordinator is employed to operate the activities programme for all residents. Each resident has an individual activities assessment on admission. From this information, an individual activities plan has been developed by the activities coordinator for the files sampled. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Residents interviewed commented positively on the activity programme. Residents are assisted to maintain contacts with community groups e.g. Stepping Stones. One resident is in the process of obtaining paid employment. Key support workers take residents on one:one outings. Residents are encouraged and assisted to do their own laundry and to plan for, shop and prepare meals. MHA 24: St Clair Park further assists a resident's recovery through the provision of services that includes: • Providing assistance and coaching in meeting responsibilities (cleaning, meal preparation, purchasing household provisions, laundry) in such a way as to enable each person to participate as fully as they are able without unreasonable expectations and with health and safety requirements met • Supporting residents to take responsibility for decisions about household management and activities provide support and access to community resources (for example, income support, social networks, sports, employment and/or training opportunities) where this is indicated as a support need by the person.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	All service levels: All initial care plans are evaluated by the registered nurse within three weeks of admission. The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status (link 1.3.3.3). The three monthly multidisciplinary team review documents progress toward goals and each aspect of the long-term care plan. There is at least a three-monthly review by the GP. Changes in health status are documented by support workers. Registered nurse follow up is recorded in progress notes. Care plan reviews have been completed by an RN, however, the evaluations do not fully record the progress towards meeting the goals. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan. MHA24: There is a process of formally reviewing recovery plans, goals and outcomes both with the resident and in a multidisciplinary setting. The review includes the resident and with their consent, their family and whānau. MHA 24: The recovery/support plan sets out specific plans and goals that are reviewed three-monthly with a formal reviewing at least six-monthly (link 1.3.3.3). In accordance with their plan, people using the

		service aim to progress towards more independent living, or, as mutually agreed, will maintain their level of independence by developing skills and supports.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	All service levels: The service facilitates access to other medical and non-medical services. There are close links with mental health services. Referral documentation is maintained on resident files. The registered nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the resident and family as evidenced in interviews and medical notes. Examples were provided where a resident's condition had changed and the resident was reassessed.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Documented processes for the management of waste and hazardous substances are in place to ensure incidents are reported in a timely manner. Material safety data sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas. Personal protective clothing is not always available for staff and was not always seen to be worn by staff when carrying out their duties on the day of audit (link 3.1.9).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current building warrant of fitness that expires on 6 July 2017. There is a maintenance staff member who works nine hours per week and is available on call for facility matters. Planned and reactive maintenance systems are in place. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually. Hot water temperatures have been tested and recorded monthly with corrective actions for temperatures outside of the acceptable range. The service is divided into three units, linked by corridors. Corridors allow residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. Staff stated they have all the equipment required to provide the level of care documented in the care plans.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are communal use bathrooms/toilets in the hospital. There are communal toilets and showers in each unit. There are communal toilets located near the lounge/dining rooms. Communal toilet facilities have a system that indicates if it is engaged or vacant.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There are only single rooms. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalise their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas within the facility include open plan lounge and dining area in each unit. There are smaller lounges and a family room within the facility. The communal areas are easily accessible for residents. Seating and space is arranged to allow both individual and group activities to occur.
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	FA	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There is a dedicated housekeeping staff member. The cleaning trolley is kept in designated locked cupboards. Laundry is completed by staff or by residents with staff support where able. There is one small laundry for domestic use and a larger laundry with a commercial washer and dryer. Residents interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.

provided.		
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Emergency and disaster policies and procedures are in place and there is a current emergency response plan (MHA 24). An approved fire evacuation plan is available. Fire evacuation drills take place every six months. The orientation programme (link 1.2.7.4) and annual education and training programme include mandatory fire and security training. Staff interviewed confirmed their understanding of emergency procedures. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency. A call bell system is in use. There is a minimum of one person who is available 24 hours a day, 7 days a week with a current first aid/CPR certificate. All key workers who take residents out of the facility have a current first aid certificate. External lighting and security systems are adequate for safety and security.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents were provided with adequate natural light, safe ventilation and an environment that is maintained at a safe and comfortable temperature. Smoking is discouraged and there is a smoke-free policy. The buildings are smoke-free with a designated outdoor smoking area (MHA 24).
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	PA Low	St Clair Park has an established infection control programme. The clinical leader is the designated infection control nurse with support from the other registered nurse and the manager. Audits have been conducted and include hand hygiene and infection control practices. Education is provided for all new staff on orientation (link 1.2.7.4). The infection control programme has not been reviewed annually.
Standard 3.2: Implementing the infection control	FA	The clinical leader (registered nurse) at St Clair Park is the designated infection control (IC) nurse. There are adequate resources to implement the infection control programme for the size and complexity of the

programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.		organisation. The IC nurse and IC team (comprising senior management) has external support from the local laboratory infection control team and IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies were developed by an external contractor and have been reviewed and updated.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Formal infection control education for staff has occurred. The infection control nurse has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been	FA	Infection surveillance is an integral part of the infection control programme and is described in St Clair Park's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections are entered on to a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at the monthly infection control meeting and staff meetings. If there is

specified in the infection control programme.		an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. No outbreaks have been reported since the last audit. Outbreak resources are available should they be required.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	St Clair Park maintains a restraint-free environment. The service has documented systems in place to ensure the use of restraint is actively minimised. There were no enablers in use. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enablers are voluntary. Staff education on RMSP/enablers has been provided.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data including complaints, infections and incidents is collated and analysed (there are small numbers of each). These are discussed in quality meetings as reflected in the meeting minutes and in the infection control meetings (where not all discussion is documented) as reported by the infection control coordinator. Health and safety issues are not currently discussed in meetings as confirmed by support workers, the health and safety representative and meeting minutes.	(i) Health and safety is not discussed in any facility meetings. (ii) Quality data analysis outcomes are not discussed in staff meetings. (iii) Infection control meetings do not record discussion of issues other than surveillance of infections.	Ensure that health and safety and quality data analysis outcomes are discussed in staff meetings and that all meetings have minutes accurately recorded. 90 days

Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	When internal audits have identified service shortfalls, this has been noted as a recommendation on the audit form. Corrective action plans have not always been documented to address these. There is evidence that corrective actions have been implemented, but when plans have been documented they have not routinely been signed off as completed.	Corrective action plans are not always documented when service shortfalls are identified; and when they are documented they are not always signed off as completed.	Ensure corrective action plans are documented when service shortfalls are identified and signed off when completed. 90 days
Criterion 1.2.3.9 Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.	PA Low	The service has a health and safety representative who completed training in the two days prior to the audit and when interviewed demonstrated an understanding of the requirements of a current hazard register. The hazard register was not current.	The hazard register had not been reviewed since May 2014.	Ensure the hazard register is reviewed regularly. 90 days
Criterion 1.2.6.1 The service demonstrates family/whānau and community participation where relevant,	PA Low	The service actively contacts or leaves messages for families regarding the residents and families are invited to complete the annual relatives' survey. There is a comprehensive policy outlining the	The processes described in policy to involve family in all	Ensure a family perspective is provided in the planning,

in the planning, implementation, monitoring, and evaluation of service delivery.		processes to engage families at all levels of the service. In practice, most families do not have close involvement with the resident or the service and the policy is not implemented.	levels of the service are not implemented.	implementation, monitoring and evaluation of service delivery. 180 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	Eight staff files were sampled including three recently employed staff. Not all files (including one of the recently employed) contained evidence of reference checks and job descriptions. All contained evidence of interviews, verification of qualifications and employment contracts.	(i) Three of eight staff files sampled did not contain evidence of references having been checked. (ii) Three of eight staff files did not contain a current job description.	(i) Ensure all new staff have a reference check completed prior to employment. (ii) Ensure all staff have a current job description signed. 90 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Moderate	The service has a documented and comprehensive orientation programme. Staff reported that new support workers receive a comprehensive orientation that can be extended if required. Not all staff files sampled evidenced a documented orientation.	Six of eight staff files sampled (including three recently employed staff) did not contain a documented orientation.	Ensure all new staff complete a documented orientation. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective	PA Moderate	Staff training has been provided at least monthly for the past two years including medication training being repeated following the identification of a medication error. Staff attendance at training has been recorded for the last two trainings but not prior to this. Five	(i) Until the two most recent trainings, records of attendance have not been	(i) Ensure records of attendance are kept for staff

services to consumers.		staff have completed online staff training in 2015 and 2016. Not all required areas have been covered in training. Performance appraisals are intended to be completed annually but this had not always occurred.	kept for staff training. (ii) Staff training has not been provided around: emergencies (civil defence), health and safety, cultural awareness, abuse and neglect, falls management, pain management, wounds, skin integrity, challenging behaviours or continence. (iii) Two of eight staff files sampled did not have a current performance appraisal.	training. (ii) Ensure all required staff training is provided. (iii) Ensure all staff have an annual performance appraisal. 90 days
Criterion 1.2.9.9 All records are legible and the name and designation of the service provider is identifiable.	PA Low	Support workers, registered nurses and the activities coordinator document in progress notes, with an entry for every resident at least every shift. Progress notes are legible, dated and signed but the designation of the writer is not documented.	In six of six files sampled the progress notes did not document the designation of the writer.	Ensure the designation of the writer is documented in progress notes. 90 days

Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Low	Medications are provided by the local pharmacy and are delivered pre-packed on a four weekly basis. Medications requiring secure storage, controls and checking are appropriately managed. Twelve medication charts were reviewed and evidenced that ten were completed correctly. One resident on a regular prescribed supplement did not have this recorded as administered on a regular basis. Advised that the resident had been given the regular supplement. One resident had been given a topical treatment for seven days after the GP had ordered the ceasing of the treatment. All charts reviewed evidenced resident photograph for identification and allergies were documented.	i) Nutritional supplements for one mental health resident were not consistently signed for as given; ii) One rest home resident had had a topical ointment applied after the order had been ceased.	i) Ensure that all medication orders are signed for appropriately; ii) Ensure that medication orders are followed as written. 60 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	All service levels: The interRAI assessment tool has been used for all resident assessments. Strength assessments and recovery plans have been developed in conjunction with the resident. Assessment reviews have been completed in a timely manner for two mental health files and two rest home residents. Care plan reviews have been completed for all residents. However, these had only been completed in a timely manner for two rest home, one mental health and one resident on an ACC contract. The interRAI assessment tool has been used for all residents in the sample. The clinical leader has endeavoured to assess all residents with the interRAI tool and this has now been achieved.	i) Assessment reviews have not been completed within the required timeframes for one long term chronic health resident (was six months overdue) and one resident on an ACC contract (was five months overdue); ii) Care plan reviews have not been completed six monthly for	i) and ii) Ensure that all aspects of assessment and care plan reviews are completed within the required timeframes. 90 days

			one mental health resident (two months overdue) and one resident with a long term chronic health condition (two months overdue).	
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Long-term care plans are in place for all six of the resident files sampled. Evaluations have been completed but not all have been within the required timeframes (link 1.3.3.3). The long-term care plan reviews have included the development of a new care plan for one resident with a chronic long term health condition, and one resident on an ACC contract. The reviews for four of six long-term care plans only included a brief evaluation at the end of the care plan.	Evaluations of the long-term momentum care plan do not indicate the degree of achievement or progress towards meeting the goals (for each aspect of the care plan) in two mental health and two rest home resident files reviewed.	Ensure that each aspect of the long-term care plan is comprehensively reviewed to indicate the response to the interventions provided. 90 days
Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	PA Low	The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. The programme includes policies and procedures, surveillance of infection rates, infection prevention education and training for staff and residents. Infection rates are low. The infection control	A review of the 2015 infection prevention and control programme has not been completed.	Provide evidence that the infection control programme is reviewed annually.

		committee includes the two registered nurses, the manager and the assistant manager (activities coordinator). A review of the programme has not been conducted.		90 days
Criterion 3.1.9 Service providers and/or consumers and visitors suffering from, or exposed to and susceptible to, infectious diseases should be prevented from exposing others while infectious.	PA Low	There is personal protective equipment available for staff including eye protection, gloves, alcohol hand gel and aprons. On the day of audit, it was observed that the cleaning staff wore gloves when attending to cleaning duties however; a protective apron was not worn. Each unit has sufficient communal bathroom facilities. Three shower rooms were noted to have a stock of clean towels and facecloths in each room. These were removed on the first day of audit but replaced during the audit.	i) The cleaner did not wear a suitable protective apron during cleaning; ii) There were supplies of clean towels stored in communal bathroom facilities.	i) Ensure that staff use personal protective equipment to minimise the risk of spread of infection; ii) Ensure that communal bathrooms do not have stores of towels left in them. 60 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.