# Rowena Jackson Retirement Village Limited

## Introduction

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

The audit has been conducted by 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](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:** Rowena Jackson Retirement Village Limited

**Premises audited:** Rowena Jackson Retirement Village

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

**Dates of audit:** Start date: 30 November 2016 End date: 1 December 2016

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 153

# 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

Ryman Rowena Jackson provides rest home, hospital (geriatric and medical) and dementia level care for up to 157 residents in the care centre and up to an additional 15 residents in serviced apartments. On the day of the audit there were 153 residents. The service is managed by an experienced village manager. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

Two shortfalls from the previous audit around performance appraisals and timeliness of resident documentation have been addressed. This audit did not identify any further areas requiring improvement. The previous continuous improvement achievement around quality goal implementation continues to attain a continuous improvement rating.

## 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. |

There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## 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. |

Services are planned, coordinated and are appropriate to the needs of the residents. A village manager, assistant manager and clinical manager are responsible for the day-to-day operations. Goals are documented for the service with evidence of regular reviews. A comprehensive quality and risk management programme is in place. Corrective actions are implemented and evaluated where opportunities for improvements are identified. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is implemented for new staff. Ongoing education and training includes in-service education and competency assessments.

Registered nursing cover is provided seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## 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. |

InterRAI assessments, risk assessments, care plans, interventions and evaluations are completed by the registered nurses. Care plans demonstrate service integration. Residents and family interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme which is varied and interesting. The Engage programme meets the abilities and recreational needs of the group of residents. Residents are encouraged to maintain links with community groups.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

The menu is designed by a dietitian at an organisational level. All baking and meals are cooked on-site. Individual and special dietary needs are accommodated. Nutritious snacks are available 24 hours in the dementia care unit.

## 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. |

A current building warrant of fitness is posted in a visible location.

## 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. |

Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were no residents with restraint and one resident with an enabler at the time of the audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

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

The infection prevention and control programme includes policies and procedures to guide staff. The infection prevention and control team holds integrated meetings with the health and safety team. A monthly infection control report is completed, trends identified and acted upon. Benchmarking occurs and a six-monthly comparative summary is completed. Three outbreaks have been well managed.

## 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** | 1 | 38 | 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 service has a complaints policy that describes the management of the complaints process. Complaints forms are available throughout the facility. Information about complaints is provided on admission. Interviews with all twelve residents (seven rest home including one in a serviced apartment and five hospital) and family confirmed their understanding of the complaints process. Complainants are provided with information on how to access advocacy services through the HDC Advocacy Service if resolution is not to their satisfaction.Interviews with three managers (village manager, assistant village manager, clinical manager) and twenty-five staff (eleven care assistants (six hospital, three rest home, one serviced apartments and one dementia), eight registered nurses (RNs), one enrolled nurse(EN), three activities staff, one head chef and one education coordinator) confirmed their understanding around the processes implemented for reporting and managing complaints.There is a complaint register that includes written and verbal complaints, dates and actions taken and demonstrates that complaints are being managed in a timely manner. The complaints process is linked to the quality and risk management system. Following a complaint to the Health and Disability Commissioner in March 2016 a number of corrective actions were implemented. These included:Continence training 4/3/16 after original complaint, extra continence product training 9/6/16 – all through with compulsory for Salisbury• Every resident has a primary carer appointed for duration of stay. This is identified by colours on the roster and supported by fixed rosters. Rowena Jackson continues to evaluate and refine system• Provision of education about intentional rounding in September 2015 and in handovers. Records demonstrate this practice is embedded.• Extraordinary meeting in Salisbury attended by 24 staff who work in Salisbury on 13 April 2016 that covered: ‘Who are primary residents, what do residents need?’ (Cares etc. –a detailed discussion about all aspects), what does the primary team meeting include? (Noticing and reporting physical, social and emotional changes, liaising with families – especially the good things), documentation, what to report and who to, continence (20% of residents do not fit the ‘typical’ product formula), communication and swapping residents (this is not to happen). |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay for that are not covered by the agreement. The information pack is available in large print and in other languages. It is read to residents who are visually impaired. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Regular contact is maintained with family including if an incident or care/health issues arise. Evidence of families being kept informed is documented on the electronic database and in the residents’ progress notes. All eight family members interviewed (two dementia level, one rest home level and five hospital level) stated they were well-informed. Ten incident/accident forms and corresponding residents’ files were reviewed (from across all service levels and including rest home level residents in serviced apartments) and all identified that either the next of kin were contacted or requested not to be contacted (minor events only). Regular resident and family meetings provide a forum for residents to discuss issues or concerns. Interpreter services are available if needed for residents who are unable to speak or understand English.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Rowena Jackson is part of a wider village. The service provides rest home, hospital (geriatric and medical), and dementia level care for up to 157 residents in the care area. Additionally, there are 15 certified serviced apartments.In the rest home, there are 10 dual-purpose beds and all hospital are dual-purpose. On the day of the audit, there were 58 hospital residents, 70 rest home residents (60 in the 61 bed rest home area including 1 resident on respite care), 5 in the hospital area and 5 in serviced apartments) and 25 residents in the 26 bed dementia unit. The hospital is divided into two wings. O’Byrne wing has 36 of 40 beds occupied (this included 3 rest home residents noted above and 1 funded hospital level respite resident). Salisbury is a 30 bed wing and 28 beds were occupied. This included two rest home residents (noted above), one boarder (who is independent and does not receive any care services), one resident who is private paying on short-term medical care post-surgery and one resident funded by the DHB on a short-term medical contract.There is a documented service philosophy that guides quality improvement and risk management. Specific values have been determined for the facility. Organisational objectives for 2016 are defined with evidence of monthly reviews and quarterly reporting to senior managers on progress towards meeting these objectives. The village manager has been in the position for 12 years. She is a registered nurse with a current practising certificate. She has attended over eight hours (year to date) of professional development activities related to managing an aged care facility. The village manager is supported by a regional manager, an assistant manager who has been in the position for three years and a clinical manager/RN who has also been in the position for three years. The management team have each completed in excess of eight hours of training related to managing a hospital in the past year.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Rowena Jackson has a well-established quality and risk management system that is directed by Ryman head office. Quality and risk performance is reported across the facility meetings and to the organisation's management team. Discussions with the management team (village manager, assistant manager and clinical manager) and staff, and review of management and staff meeting minutes demonstrate their involvement in quality and risk activities. Family meetings are held six-monthly and residents’ meetings are held every two months. Minutes are maintained. Annual resident and relative surveys are completed. Quality improvement plans are completed with evidence that suggestions and concerns are addressed.The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed at a national level and are forwarded through to a service level in accordance with the monthly team. They are communicated to staff, as evidenced in staff meeting minutes. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery. There are clear guidelines and templates for reporting. Management systems, policies and procedures are developed, implemented and regularly reviewed. The facility has implemented processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflect actions being implemented and signed off when completed. The service has exceeded the required standard in this area. Health and safety policies are implemented and monitored by the two-monthly health and safety meetings. A health and safety representative is appointed who has completed health and safety training. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. Ryman Rowena Jackson has achieved tertiary level ACC Workplace Safety Management Practice. The hazard identification resolution plan is sent to head office and identifies any new hazards. A review of this, the hazard register and the maintenance register indicates that there is resolution of issues identified. Falls prevention strategies are in place. Lounge carers monitor residents in the lounges.  |
| 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 | There is an incident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Individual incident reports are completed electronically for each incident/accident with immediate action noted and any follow up action required. A review of ten recent incident/accident forms from across all areas of the service including the serviced apartments, identified that all are fully completed and include follow up by a registered nurse. The clinical manager is involved in the adverse event process, with links to the applicable meetings (teamRyman, RN, care staff, health and safety/infection control). This provides the opportunity to review any incidents as they occur.The village manager is able to identify situations that would be reported to statutory authorities. An appropriate section 31 notification was made around a pressure injury and three outbreaks were notified to the appropriate departments.  |
| 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 | There are comprehensive human resources policies including recruitment, selection, orientation and staff training and development. Nine staff files reviewed (three care assistants, three registered nurses (including the clinical manager and one unit coordinator), one chef, one activities assistant, one diversional therapist) provided evidence of signed contracts, job descriptions relevant to the role the staff member is in, induction, application form and reference checks. All files reviewed included annual performance appraisals with eight week reviews completed for newly appointed staff. This is an improvement since the previous audit. A register of RN and EN practising certificates are maintained within the facility. Practising certificates for other health practitioners are retained to provide evidence of registration.An orientation/induction programme provides new staff with relevant information for safe work practice. It is tailored specifically to each position. There is an implemented annual education plan. The annual training programme exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Twelve care assistants work in the dementia unit. Eleven have completed their dementia qualification. The remaining staff member is enrolled and has been employed to work in the dementia unit for less than one year.Registered nurses are supported to maintain their professional competency. Staff training records are maintained. There are implemented competencies for RNs, ENs and care assistants related to specialised procedures or treatments including medication competencies and insulin competencies. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | A policy is in place for determining staffing levels and skills mix for safe service delivery. This defines staffing ratios to residents. Rosters implement the staffing rationale. The service is divided into a rest home wing, a dementia unit and two hospital units. Staffing is allocated per unit, depending on occupancy and acuity. There is a unit coordinator for one hospital wing (O’Byrne), one for the other hospital wing (Salisbury) and the dementia unit and one for the rest home and serviced apartments. Two of the unit coordinators are registered nurses and the rest home unit coordinator is an enrolled nurse. The unit coordinators all work 40 hours per week and the days are scheduled so that there is either the clinical manager or two unit coordinators on duty seven days per week. In addition there is a registered nurse on duty from 7 am to 11 pm, seven days per week in the rest home, a registered nurse on morning shift seven days per week and either a registered nurse or an enrolled nurse on duty on the afternoon shift in the dementia unit and two registered nurses on morning and afternoon shift and one on night shift in each of the two hospital units.The village manager and clinical manager alternate weekends on call and one of the unit coordinators is on call each day/night during the week.A registered physiotherapist is available 15 hours a week and a physiotherapy assistant carries out the rehabilitation programmes developed by the physiotherapist. There are separate laundry and cleaning staff.Staff on the floor on the days of the audit were visible and were attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the management team provide good support. Residents and family members interviewed reported there are adequate staff numbers. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. Medicine management complies with Ministry of Health medication requirements. Medication reconciliation of monthly blister packs is completed by RNs and any errors are fed back to pharmacy. Registered nurses, enrolled nurses and senior care assistants who administer medications have been assessed for competency on an annual basis. Care staff interviewed were able to describe their role in regard to medicine administration. Registered nurses observed on medication rounds followed correct procedures. Education around safe medication administration has been provided. Medications were stored safely. Medication fridges were monitored daily. All eye drops and creams were dated on opening. Residents have photo identification on medication charts and allergies are recorded.One self-medicating hospital resident had been assessed and reviewed by the GP and RN as competent to self-administer. Eighteen paper based medication charts (nine hospital, five rest home and four dementia care) were reviewed and evidenced that all medication documentation has been completed appropriately including charting and administration signing. The effectiveness of ‘as required’ medications is recorded in progress notes.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All food and baking is prepared and cooked on-site. The qualified head chef is supported by a weekend chef, cooks and kitchen assistants. Staff have been trained in food safety and chemical safety. There is an organisational four-weekly seasonal menu that had been designed in consultation with the dietitian at organisational level. Meals are delivered in hot boxes and served from bain maries in the kitchenettes. Residents have a choice of three choices for the lunch time main meal and two meal options for the evening meal. The cook receives a resident dietary profile for all new admissions and is notified of any dietary changes. Resident likes, dislikes and dietary preferences were known. Alternative foods are offered. Cultural, religious and food allergies are accommodated. Special diets such as pureed/soft diets are provided. Nutritious snacks are available 24 hours in the dementia unit. Freezer and chiller temperatures and end cooked temperatures are taken and recorded twice daily. Chilled goods temperature is checked on delivery. Twice daily food temperatures are monitored and recorded. All foods were date labelled. A cleaning schedule is maintained. Staff were observed to be wearing appropriate personal protective clothing. Residents have the opportunity to provide feedback on the meals through resident meetings, survey and direct contact with the chef.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents interviewed reported their needs were being met. The family members interviewed stated their relative’s needs were being appropriately met. When a resident's condition alters, a registered nurse initiates a review and if required, a GP visit or nurse specialist consultant. Care plans reviewed were updated to reflect the changes in resident needs/supports. Short-term care plans are developed for infections. Wound assessments, treatment and evaluations were in place (on the electronic database) for nine residents with wounds (skin tears, lesions and chronic ulcers). There were six residents with facility acquired pressure injuries on the day of audit (two stage I, three stage II and one stage III). Adequate dressing supplies were sighted in the treatment rooms. The RNs could describe access to the DHB wound nurse or district nurses as required. The GP reviews wounds three-monthly or earlier if there are signs of infection or non-healing. Chronic wounds and pressure injuries are linked to the long-term care plans. Continence products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RN's interviewed. Monitoring forms in place include (but not limited to): monthly weight, blood pressure and pulse, neurological observations post unwitnessed falls or identified head injuries, food and fluid charts, restraint monitoring, pain monitoring, blood sugar levels and behaviour charts. Progress notes document changes in health and significant events.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | There is a team of six activities staff members (with one progressing through the diversional therapy level 4 training) and two diversional therapists who coordinate and implement the Engage programme across the four areas; rest home, serviced apartments, hospital and dementia care unit. Activity staff attend on-site and organisational in-service training relevant to their roles. All staff have current first aid certificates.The Engage programme has set activities with the flexibility for each service level to add activities that are meaningful and relevant for the resident group including Triple AAA exercises, walking groups, themes events and celebrations, indoor bowls, baking and cooking, games, entertainment, outings and drives. Activities are provided Monday to Sunday in each unit. The dementia unit also has an evening programme which runs until 8pm. Two vans are available for outings for all residents. Dementia unit residents have weekly outings. The internal garden courtyard in the secure unit allows for dementia residents to safely wander. Rest home residents in the serviced apartments attend the serviced apartment programme. The activities staff interviewed advised that they make daily contact with all residents and one-on-one time is spent with those residents who choose not to be involved in the activity programme. Community involvement includes entertainers and church services. Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The resident/family/whānau as appropriate are involved in the development of the activity plan. Residents/relatives have the opportunity to feedback on the programme through the resident meetings and satisfaction surveys.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long-term care plans reviewed had been evaluated by registered nurses for long-term residents who had been at the service six months. One dementia unit resident does not yet have a long-term care plan and one rest home resident was on respite care. Written evaluations for long-term residents describe the resident’s progress against the resident’s identified goals and any changes are updated on the long-term care plan. The multidisciplinary review involves the RN, clinical manager, GP, care assistant, activities staff and other allied health professionals involved in the care of the resident. The family are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. The family members interviewed confirmed they had been invited to attend the multidisciplinary care plan reviews and GP visits.  |
| 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. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy describes the purpose and methodology for the surveillance of infections. Definitions of infections are appropriate to the complexity of service provided. Individual infection report forms are completed for all infections and are kept as part of the resident files. Infections are included on an electronic register and the infection prevention and control officer (registered nurse) completes a monthly report. Monthly data is reported to the combined infection prevention and control/health and safety meetings. Staff are informed through the variety of clinical meetings held at the facility. Meeting minutes include identifying trends, corrective actions and evaluations are available on the staff noticeboard. The infection prevention and control programme links with the quality programme. There is close liaison with the GPs and laboratory service that advise and provide feedback and information to the service. Systems in place are appropriate to the size and complexity of the facility. The service has had three outbreaks in 2015 and 2016. The first, in November 2015 was contained to the serviced apartment area and two of the eight rest home level residents in the serviced apartment area were affected. The second, in December 2015 was contained to the rest home area and one resident in the dementia unit. Staff identified that this dementia resident had been visited by someone who had also visited the rest home area the day before the outbreak and isolated the dementia resident before symptoms were present to reduce the risk of spread of the infection.The third outbreak in October 2016 was contained to four residents (all on one side) of the dementia unit. When the outbreak was identified the two sides of the dementia unit were separated. Three staff (the primary carers of the residents) were also affected.A further outbreak was initially reported in April 2016 but no resident had a second episode of loose bowls and laxative use on the morning shift was identified as the issue. No outbreak number was issued.The service has worked closely with Public Health around outbreak management and has implemented all suggestions. In their outbreak report, Public Health complimented Rowena Jackson on their management of the outbreaks.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers. On the day of audit, there were no residents with restraint and one using an enabler. Enabler use is voluntary. Staff training has been provided around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours. |

# 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.

|  |
| --- |
| 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | Rowena Jackson develops quality goals based on quality data trends, resident and relative satisfaction results and audit outcomes. The intention of the goals is to improve outcomes and satisfaction for residents and to provide an effective service. The goals are developed at the beginning of each year with staff consultation and are reviewed quarterly. The outcomes for the 2015 goals demonstrated improvements for residents and the 2016 goals are currently being implemented and reviewed.  | Rowena Jackson develops a set of quality goals each year and reviews them at least monthly with staff to ensure that the goal implantation results in improved outcomes for residents.One of the four goals for 2015 included that Rowena Jackson be the best place to live. A number of initiatives were introduced throughout the year to attain this. They included (but were not limited to): increased general practitioner hours, the development of an email booking system with the NASC, the development of a men’s club and an ‘old girls club’. The implantation of initiatives to achieve this goal and the goals to make Rowena Jackson the best place to work and to ensure all registered nurses were well trained in using nursing care plans resulted in overall satisfaction survey ratings increasing by 21% from the 2015 survey to the 2016 survey. Additionally, there has been a significant reduction in the number of complaints received. |

End of the report.