

Castlewood Nursing Home Limited - Castlewood Nursing Home

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Castlewood Nursing Home Limited

Premises audited: Castlewood Nursing Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 9 November 2016 End date: 10 November 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: 18

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
Yellow	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
Red	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

Castlewood Nursing Home provides rest home level care for up to 24 residents. Occupancy on the days of audit was 18 residents, one of whom had been assessed as requiring hospital level care and was awaiting transfer to a hospital level facility.

This unannounced surveillance audit was undertaken to monitor compliance with specified parts of the Health and Disability Services Standards and the Southern District Health Board Aged Residential Care contract.

The areas identified as requiring improvement at the last certification audit relating to: advance directives, policy documentation, analysis of data, progress note documentation, service delivery timeframes, assessment, initial care plans, planned activities, short-term care plans, medication management, self-administration of medicine, dietitian review of menu, communication of resident nutritional requirements, food storage and infection control, were implemented.

This surveillance audit identified new areas requiring improvement including corrective actions from incidents and accidents, performance appraisals and the building warrant of fitness.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Information, the complaints process and the Nationwide Health and Disability Advocacy Service information, is available. This information is given to residents and their families on admission to the facility. The manager is responsible for management of all complaints. Interviews confirmed that staff are respectful of residents needs and communication is appropriate.

There are adequate communication systems to ensure effective communication between staff and residents and their families, and with other health providers. Open disclosure is encouraged and understood by staff and the general practitioner interviewed. There are processes in place to access translation and interpreting services when required.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The manager is responsible for facility management and the clinical nurse manager is responsible for oversight of clinical care. Quality improvement data is collected, collated, analysed and reported through the staff meetings. The service has policies and procedures that are aligned with current good practice. The service has a document control system to manage all their policies and procedures. Key quality indicators are included in the business plan. The service has a quality and risk management system,

including adverse event reporting and risks and hazard management. Risks are addressed and communicated to residents, their families and staff.

Adverse events are documented and discussed with residents and/or their family. The service provider understands their statutory obligations regarding essential notification. Any service shortfalls are documented..

There are human resource policies implemented relating to recruitment, selection, orientation and staff training and staff development. Professional qualifications are validated and registration with professional bodies is verified. The rationale for determining staffing levels and skill mix is documented in policy and implemented. The manager and an on-call roster are available for support after hours. Where issues are of a clinical nature there is a documented system for after hours clinical support if required. Duty rosters sighted confirm that there is adequate staff available.

Resident record entries are legible with dates, signatures and staff designations included. All individual resident records are integrated and stored securely and appropriately. A well maintained register is kept of all required resident information.

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.		Standards applicable to this service fully attained.
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The processes for planning, provision of care, evaluation and review of care, and exit from the service are provided within timeframes that safely meet the needs of the residents and contractual requirements. The service is coordinated in a manner that promotes continuity of service delivery. The care plans describe the needs and interventions required to meet goals set. Where progress is different to that expected, the service responds by initiating changes to the care plan or with the use of short-term care plans.

The service has a planned activities programme based on activities that are meaningful to the residents individually. Activities are aimed at developing new skills and interests and maintaining independence.

There are processes in place for a safe medicine management system. Staff responsible for medicine management have been assessed as competent to perform this function for each stage they manage.

The residents and family are pleased with the meal service. Recommendations from the dietician audit have been taken into consideration. Staff in the kitchen have received full training in food safety and hand hygiene.

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.		Some standards applicable to this service partially attained and of low risk.
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The facility provides a suitable physical environment specific to the needs of the residents. Equipment complies with legislative requirements. The physical environment reduces risks and promotes safety and independence for residents. Residents are provided with accessible and safe external areas.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures reflect current good practice and meet legislative and disability service standard requirements. Enablers are described as voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education plan. At the time of this audit no restraint or enablers are 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.

Standards applicable to this service fully attained.

Surveillance for infections is undertaken monthly. Results of surveillance is analysed to assist in achieving infection reduction. The infection surveillance results are appropriately reported to staff and management in a timely manner.

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	17	1	2	0	0	0
Criteria	0	47	1	2	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>The Castlewood Nursing Home policy and cardiopulmonary resuscitation form has been reviewed and implemented to avoid any confusion. The definition of resuscitation is clearly defined. There are now two parts: one to be signed and dated by the general practitioner (GP) and the other part by the individual resident. The forms are kept in the individual resident records reviewed. The GP interviewed discussed the new form and advance directives are made available to service providers and are acted on where valid. The previous requirement for improvement relating to advanced directives has been implemented.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected,</p>	FA	<p>The facility has systems in place to manage the complaints processes. The complaints process records a summary of the complaint, the investigation, outcome and other processes of complaints management. All complaints have resolution and documentation to support closure. Complaints policies and procedures are compliant with Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights Information (the Code). The complaints register records the complaints, date and actions taken.</p> <p>Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint</p>

<p>and upheld.</p>		<p>processes and the Code. The complaint process is readily accessible and complaints forms are displayed for easy access. Residents and family interviewed confirm having an understanding and awareness of these processes.</p> <p>Resident meetings are held two monthly. Residents and their families are able to raise any issues they have during these meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy was reviewed and clearly describes the principles of open disclosure and providing full and frank information as required. Family confirmed they are kept informed of the resident's status and are notified of any adverse events. The family contact record is visible in all resident records reviewed. Details from doctor's visits are documented and communicated as required.</p> <p>The organisation has an interpreter policy and procedure to guide staff. Contact details for interpreters and translation services are available if needed. Cultural advisors can be contacted through the district health board (DHB) and locally to meet the needs of residents.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The manager has been acting in the role as facility's full time manager, since the resignation of the clinical nurse manager 30 September 2016 and until a new appointment is made. The manager, registered as a psychiatric nurse in 1974, but has not held an annual practicing certificate for the last two years. The manager has previous experience in the health sector and a degree in business studies. The interim appointment of the manager was confirmed with HealthCERT, date of notification confirmed. The manager resides on site and is available on call if needed for non-clinical matters.</p> <p>The manager is supported by two registered nurses, who job share to provide a minimum of 30 hours per week Monday through to Friday. The two registered nurses have shared responsibility for all clinical matters. Both registered nurses have current annual practising certificates, and have worked for the facility for over one year.</p> <p>The facility has capacity for up to 24 residents and had a bed occupancy of 18 on the days of the audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>PA Low</p>	<p>The facility implements organisational policies and procedures to support service delivery. All policies are subject to review and are current. All policies are reviewed with input from an external consultant (a senior registered nurse from Dunstan Hospital) and staff. Policies are linked to the relevant Health and Disability Sector Standards, current and applicable legislation, and evidenced based best practice guidelines. Policies are available to staff in hard copy. New and revised policies are presented to staff at staff meetings. Service delivery meets the requirements of legislation, and is reviewed at regular intervals as defined by their policy.</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>A business plan and a quality and risk management plan were reviewed. These guide the quality programme. Each aspect of service delivery is reviewed by a registered nurse using a monthly audit schedule to ensure that all audits are completed in a timely manner. Family, resident and staff satisfaction surveys are completed as part of the audit programme. Collated results for surveys were reviewed and these indicate satisfaction with services. There are two monthly resident meetings that include family if they wish to attend.</p> <p>The risk management programme includes health and safety policies and procedures. Health and safety audits are completed as part of the annual audit programme. There is evidence that any identified hazards are signed off as addressed or risks minimised or isolated.</p> <p>Service delivery is monitored through complaints, incidents and accidents, and implementation of an internal audit programme. However, there is a requirement for improvement relating to the identification, recording and closing out of corrective actions arising from incidents and accidents. Clinical indicators and quality improvement data is recorded and there is documented reporting that includes the collection and collation of quality improvement data, the analysis of results and identification of trends.</p> <p>The registered nurse provides monthly reports to the manager, who is also the owner, at management and staff meetings. Reports include quality and risk management issues, occupancy, internal audit outcomes and clinical indicators. Reports include quality and risk management issues, occupancy, internal audit outcomes and clinical indicators.</p> <p>There are monthly business group meetings with the manager and registered nurses; and monthly staff meetings that include reviews of quality data, policy updates and health and safety. Meeting minutes evidence communication with staff regarding all aspects of quality improvement and risk management. All meetings have an agenda and minutes are maintained with the identification of people responsible for outcomes and timeframes.</p> <p>The previous requirement for improvement relating to updating and development of essential policies has been implemented.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers</p>	<p>FA</p>	<p>The manager is aware of situations in which the service would need to report and notify statutory authorities, including police attending the facility for example, unexpected deaths, sentinel events, infectious disease outbreaks and changes in key managers.</p> <p>Staff document adverse, unplanned or untoward events on an accident/incident form. Incident and accident forms are reviewed and corrective actions are implemented by the registered nurse. However, the records sighted did not evidence consistent documentation of the incident, the corrective action, the person responsible for close out (refer to 1.2.3.8). Incident and accident records include absent without leave, skin tears, falls, medication errors and infections. Staff confirmed during interview that they are aware of their responsibilities for documentation of adverse events.</p>

<p>and where appropriate their family/whānau of choice in an open manner.</p>		<p>Monthly reports are produced by the registered nurse that demonstrate the analysis of trends related to incidents and accidents and evidence of improvement of service delivery as a result of the analysis. Data is reported monthly at the business group meetings, with the manager and registered nurses and also at the monthly staff meetings.</p> <p>The previous requirement for improvement relating to incidents and accidents analysis and trending has been met.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Low</p>	<p>There are written and implemented policies and procedures in relation to human resource management. The skills and knowledge required for each position are documented in job descriptions which outline accountability, responsibilities and authority. These are included on staff files along with employment agreements, reference checks, police vetting results, completed orientation and evidence of training.</p> <p>An orientation/induction programme is available that meets the educational requirements of the Aged Residential Care (ARC) contract and new staff complete this within three months of commencing employment. File reviews confirm that annual medication competencies are completed by registered nurses (RN) and senior health care staff and copies of these are retained on staff files.</p> <p>Both RNs hold current annual practising certificates. There is an implemented annual training plan and monthly training sessions are held for all staff at team meetings.</p> <p>There is an annual performance appraisal schedule; however, there is a requirement for improvement relating to the completion and documentation of a current staff appraisal for all staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. There are nineteen staff, including the manager, an activities coordinator, one cleaner Monday to Friday, two cooks covering seven days per week and health care assistants.</p> <p>Two registered nurses (RN) cover a morning shift from 8.15 am to 2.45 pm, Monday to Friday. Castlewood does not require their RNs to be on call; however, will pay the RN at specified rates for providing advice or returning to duty if contacted (letter sighted). There is a staff assistance procedure to guide staff requiring assistance. The procedure includes dialling 111 for emergencies, contacting a doctor if the resident is unwell, advice from Healthline, and contacting the doctor or off-duty RN for medication errors.</p> <p>Five rosters were reviewed and there is sufficient staff cover to provide the services to rest home level residents. Health care assistants, residents and family interviewed reported there are sufficient staff available.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Resident personal information is entered in all individual resident records reviewed. Records sighted evidenced entries being documented which are legible with dates, signatures and staff designations included. All individual resident records are integrated. The national health index (NHI) numbers are included on all pages sighted. No personal information is displayed in public view. The resident records are kept securely in a locked filing cabinet with additional security system in place at the nurses' station. The records are stored appropriately and an archive system is in place if retrieval is required. A register is kept of all required resident information and is well maintained by the registered nurses and/or the manager. The previous requirement for improvement relating to entries to progress notes is fully implemented.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medication management is in line with legislative requirements and with the Medication Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of the audit. The staff member observed demonstrated good knowledge and has a clear understanding of the role and responsibilities related to each stage of medicine management. All senior caregivers and the two registered nurses are competent to perform this function.</p> <p>Medications are supplied in a blister pack form from the contracted pharmacy. One of the two registered nurses always checks the medication on arrival from the pharmacy. The GP reviews all medication records three monthly. Clinical pharmacist input can be verified on the medication records sighted. Photo identification of all residents is visible on all medication records and any discontinued medication is signed off and dated and ruled through appropriately as per protocol. This was an improvement from the previous audit in relation to the PRN (as necessary medication). All indication for use and maximum dosage is now recorded and the discontinued medication records are fully completed and signed off by the GP. Obsolete medications are now stored in the resident file, medication storage is secured at all times and resident photographs with consent have been added onto the medication record of identification purposes. These improvements have all been fully addressed</p> <p>No residents are currently using a controlled drug. Medications are stored in a locked cupboard. There was an improvement required in relation to residents who self-administer medications. The service now has a policy and self-administration guidelines to assess if a resident is competent to administer their own medicines. The GP would be involved as well and permission granted for this to occur.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	<p>FA</p>	<p>The food service is provided on site by employed staff and is in line with recognised nutritional guidelines for older people. There is one main cook and a relief cook available. The menu plans have been reviewed by a dietician as suitable for older persons and recommendations provided have been addressed to improve the quality of this area of service delivery. The four week menu plans are displayed. Winter and summer foods and variety of foods to suit</p>

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>seasons are considered when purchasing the food. The two cooks have completed food safety training. The registered nurses complete a nutritional profile for each individual resident on admission and the cook receives a copy. This is an improvement addressed from the previous audit. Any special diets are catered for and all likes and dislikes are considered for each resident.</p> <p>Temperature monitoring occurs for the fridges and freezers used and the outside cooler. These are monitored daily and temperatures are recorded accurately. Food temperatures are maintained for food deliveries and for presentation of food at meal times. Kitchen cleaning schedules are now recorded. These are previous improvements which have been addressed. Staff in the kitchen have meetings quarterly and minutes of the meetings were reviewed. The kitchen is clean and additional cleaning schedules are available and are up to date. Special equipment to meet resident's nutritional needs is available.</p> <p>The manager is responsible for the ordering of all food and preferred providers are utilised with some food stuffs being purchased locally from the community. All storage is managed effectively. No decanted foods were detected on visual inspection and nutritional assessments have been addressed, closing out previous required improvements..</p> <p>There is sufficient staff on duty in the dining room at meal times to ensure assistance to residents as needed. Residents and family interviewed are satisfied with the meal service.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All resident records reviewed had initial in-depth nursing assessments and initial care plans that were fully completed. The long-term care plans are developed after the interRAI assessment is performed at 21 days post admission. Additional recognised risk assessments are also evident as needed for each resident for example: continence assessment; pain assessment; pressure area assessment; mini nutritional assessment and others as required. The assessments serve as the basis for service delivery planning. There is evidence of family/whānau and resident input into care planning. This was an area of improvement from the previous audit which is closed out.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>FA</p>	<p>The residents and family/whānau reported that the staff have excellent knowledge and care skills. The GP expressed satisfaction with the care provided. The provision of services and interventions was clearly documented for the rest home residents. The care plans were individualised and personalised to meeting specific assessed needs of each resident and evidenced a person centred approach to care. The care was flexible and focused on promoting quality of life for the residents. Residents and family reported satisfaction with the care and service delivery.</p>

desired outcomes.		
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is a planned monthly programme that is developed and implemented. The programme is displayed weekly on the whiteboard and individual copies are in each resident's room. The programme is varied with some flexibility with entertainment, outings to the community, crafts, exercises to music, bingo and other activities that are meaningful to the residents. The facility has one van and shares a total mobility van with another facility for outings in the community.</p> <p>The activities coordinator is skilled at this role and ensures the activity needs are evaluated six monthly or more often if required. The goals and interventions to achieve goals set are documented. All attendances are recorded and records were available and sighted. This was an area for improvement which has been addressed. The resident and family surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme interesting and enjoyable.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluations are planned to be conducted at least six monthly or if there is a change in a residents' health status. Six monthly interRAI reassessments are also performed. These are completed by the two registered nurses as per the schedule sighted.</p> <p>The short-term care plans evidenced interventions are evaluated more frequently until the problem is resolved. Short-term care plans are used for wound care, continence review, falls risk management or other safety reasons until the resident is satisfactory. Short-term care plans was an area of improvement identified in the previous audit that has been addressed.</p> <p>Where progress is different from expected, the service responds by initiating changes to the care plan. Family are notified and this is recorded on the family communication record and documented in the progress records reviewed. The residents/family/whānau provided examples of involvement in the evaluation of progress and any resulting changes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	PA Negligible	<p>The expiry date of the building warrant of fitness on display is 20 May 2016 and there is a requirement for improvement relating to obtaining a current building warrant of fitness. There have been no building modifications since the last audit.</p> <p>The manager addresses any adhoc and scheduled maintenance and the business plan identifies planned structural changes and enhancements.</p> <p>Checking and calibrating of clinical equipment is up to date and test and tagging of electrical equipment is up to date.</p>

		<p>Observation of the facility confirms that there is adequate and suitable equipment including; shower chairs; hoists and mobility aides. The physical environment is safe for mobility with the flooring free from obstacles and trip hazards, the correct use and availability of mobility aids observed.</p> <p>Rooms are generously proportioned and decorated with residents own personal belongs. There are areas throughout the facility suitable for residents and visitors to meet in private. There is a sun porch and external areas with verandas, as well as easy access to shaded garden areas with seating. Residents and family members confirm that the environment is suitable to meet their needs.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The infection prevention and control programme reviewed is appropriate for the size and the nature of this aged care setting. There are clear definitions of infection prevention and control and the programme is reviewed annually. This was a requirement for improvement from the previous audit that has been addressed. There are clear lines of accountability and the registered nurse infection prevention and control coordinator reports to the manager monthly.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>There is an infection control surveillance policy to guide staff which was reviewed. Surveillance minimises the risk of infection for residents, staff and visitors to this service.</p> <p>The service conducts monthly surveillance for infections. The service uses standardised definitions of infections that are suitable for this long-term care setting. The surveillance data is analysed by the registered nurse infection prevention and control coordinator, reviewed and trended. Any trends identified are discussed at the quality and staff meeting. Additional actions are also discussed and implemented as needed. Graphs are produced and a summary is used to compare with the previous months infection prevention and control rates. Surveillance is appropriate for the size and nature of this rest home service.</p> <p>Any new infections and required management plans are discussed with staff at handover, to ensure early intervention occurs. Staff interviewed understand the principles of infection control and report any signs and symptoms or if residents are unwell to the registered nurses and/or to the GP as necessary.</p>
Standard 2.1.1:	FA	<p>The facility follows the restraint minimisation and safe practice policy reviewed. The policy and procedures meet</p>

<p>Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. There were no restraints or enablers being used at this service. Staff interviewed demonstrated an understanding of the definition of an enabler and that this was used as a voluntary option only for safety purposes.</p> <p>Restraint and behavioural management is included in staff orientation/induction processes. Ongoing education is identified on the staff training plan sighted.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Service delivery is monitored through complaints, incidents and accidents, implementation of an internal audit programme. However, corrective action plans for incidents and accidents addressing areas requiring improvement in order to meet the specified standard or requirements, are not consistently developed and implemented.	<p>Corrective actions for incidents and accidents do not consistently:</p> <p>Identify detail.</p> <p>Demonstrate implementation of corrective actions.</p> <p>Identify the person responsible for the implementation</p>	<p>Consistently identify corrective actions.</p> <p>Consistently implement corrective actions.</p> <p>Identify the person responsible for implementing corrective actions.</p> <p>Record the</p>

			<p>of corrective actions.</p> <p>Record the required timeframes for implementation of the corrective action.</p> <p>Record evidence of closing out of corrective actions.</p>	<p>timeframes for implementing corrective actions.</p> <p>Document evidence of close out of the corrective action.</p> <p>90 days</p>
<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	PA Low	<p>There is an annual performance appraisal schedule is in place; however, performance appraisals were last undertaken in July 2015.</p>	<p>Four of five staff files reviewed did not demonstrate evidence of an up-to-date performance appraisal.</p>	<p>Ensure that performance appraisals are documented and completed annually.</p> <p>90 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	PA Negligible	<p>The building warrant of fitness had expired in May 2016.. The manager advised and evidence was sighted confirming an inspection had shown some compliance matters were outstanding. Results of the last trial evacuation, evidenced that compliance was satisfactory.(Subsequent to the audit a copy of a current building warrant of fitness was provided to the audit team.</p>	<p>The facility did not have a current building warrant of fitness on display.</p>	<p>The service provider is to ensure that a current warrant of fitness is obtained and displayed.</p> <p>7 days</p>

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

No data to display

End of the report.