

# Aria Park Senior Living Limited

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## Introduction

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

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

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

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

The specifics of this audit included:

|   |  |                           |
|---|--|---------------------------|
| <b>Legal entity:</b>  | Aria Park Senior Living Limited  |                           |
| <b>Premises audited:</b>  | Aria Park Retirement Village   |                           |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care) |                           |
| <b>Dates of audit:</b>  | Start date: 18 January 2017  | End date: 18 January 2017 |
| <b>Proposed changes to current services (if any):</b>   | None   |                           |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 73   |                           |

# Executive summary of the audit

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## 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

Aria Park Senior Living trades as Aria Park Retirement Village. It is one of many aged care facilities owned and operated by the Arvida Group. The service provides rest home and hospital level care for up to 84 residents.

This surveillance audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of organisational documentation, staff records and residents' clinical records, observations, and interviews with residents, families/whanau, management, staff and a general practitioner.

Feedback from residents and family/whanau members was positive about the care and service provided.

There were no corrective actions to follow up from the previous audit. One area was identified for improvement at this audit in relation to annual appraisals not being up to date as required.

## 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. |
|--|--|--|

Residents and families/whanau receive full and frank information which reflects the principles of the open disclosure policy. The resident and their family/whanau are involved in the care planning, decision making and consent processes. Interpreter and translation services are available if required.

The service has a documented complaints management system implemented. At the time of audit there is one open complaint received via the Health and Disability Commissioner.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |
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The village manager is responsible for implementing the organisation`s business and strategic plan 2016/2017 which covers all aspects of service delivery. Quality data covers all key components of service delivery and is collected, reported and analysed monthly. Results are shared at all levels of the organisation and corrective action planning is put in place where areas of concern or deficits are found.

The quality management systems include an internal audit process, complaints management, incident/accident/near miss reporting, annual resident surveys, staff surveys, restraint monitoring, and infection prevention and control data collection. Quality and risk management activities and results are shared among management, staff, residents and families/whanau, as appropriate.

The village manager is responsible for the day to day management of the service with support from the clinical manager who is a registered nurse. Monthly reporting occurs at organisational level. Management and staff attend regular education related to the roles they undertake. Human resources policies and procedures meet legislative and good practice requirements.

Staffing numbers are decided according to a documented staffing level to ensure there is adequate staff with the skills and knowledge to meet residents' needs.

## 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. |
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The organisation works closely with the district health board Needs Assessment and Service Co-ordination Service (NASC) to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Registered nurses are on duty 24 hours each day and are fully supported by care and allied health staff and a designated general practitioner. Shift handovers and communication sheets support continuity of care.

Care plans are individualised based on a comprehensive and integrated range of clinical information and the interRAI assessments. Short term care plans are developed to manage any problems that might arise. All residents' records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Family members interviewed reported being well informed and involved in care planning and evaluation.

The planned activity programme is provided with a variety of individual and group activities. The programme is developed and implemented to ensure links with the community are maintained and that activities are meaningful to the residents. One on one activities are planned for those unable to attend the group activities provided.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using a manual system. Medications are administered by registered nurses and senior caregivers, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents. Those with special needs are also catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen is well organised, clean and meets all food safety standards. A dietitian has reviewed all menu plans and summer and winter variety plans are implemented.

## Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. |  | Standards applicable to this service fully attained. |
|--|--|--|

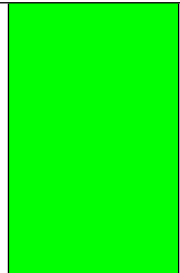
The facility undertakes process to ensure the building warrant of fitness is kept up to date.

## 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. |
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Policy states that enablers shall be voluntary and the least restrictive option to safely manage the needs of the resident. At the time of audit there are 16 restraints and five enablers in use. Staff undertake education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints and how to safely manage both processes to meet the requirements of this Standard.

## Infection prevention and control

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| <p>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.</p> |  | <p>Standards applicable to this service fully attained.</p> |
|--|---|---|

The infection prevention and control programme is led by a registered nurse who has completed training, and aims to prevent and manage infections. Staff demonstrated good principals and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged specific infection surveillance is undertaken, analysed, trended and results are reported through all levels of the organisation. Feedback is provided to staff at staff meetings and at shift handovers. The registered nurses encourage early interventions.

## 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 15                  | 0  | 1                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 38                  | 0  | 1                                    | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | <p>FA</p>         | <p>Aria Park Village implements the organisation's policies and procedures to ensure the complaints process reflects a fair system. During interview, residents, family/whanau and staff reported their understanding of the complaints process. Complaints forms are readily available to residents and visitors.</p> <p>All complaints are documented and investigated by the village manager and are signed off when they are closed. Meeting minutes show that complaints are reported at staff, management and organisational level.</p> <p>Documented complaints information is used to improve services as appropriate. Examples related to complaints follow-up include changes to the kitchen cleaning schedule and the use of pain monitoring charts related to the use of non-regular pain relief.</p> <p>There have been three complaints that have made to the Health and Disability Commissioner since the previous audit. Two occurred during the previous ownership of the facility and the corrective actions taken are embedded into everyday practice. These are now closed.</p> <p>In September 2016, when the facility was under new ownership, the Coroner forwarded family/whanau concerns about their relative's management to the</p> |

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|   |    | Health and Disability Commissioner. The service has provided all the requested documentation to the Health and Disability Commissioner within the required timeframe and are awaiting an outcome. At the time of audit this complaint remains open.  |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Staff and management confirm residents` rights to full and frank information. Family/whanau contact is documented in the residents` files and reflects the principle of open disclosure. Family/whanau confirmed they were kept well informed about any changes to their relative`s health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. There was also evidence of resident/family input into the care planning process.</p> <p>The service has processes in place to ensure residents are able to communicate their needs and understand what staff are asking. Interpreter services access is identified in policy. Staff and management were aware of how to contact approved interpreter services. An example of interpreter service use was sighted in documentation.</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> | FA | <p>Aria Park Village is owned by the Arvida Group. The organisation`s business plan for 2016-2017 was sighted. The business plan is monitored monthly by management to measure progress towards meeting goals. The general manager of Wellness and Care confirmed that the Arvida Group vision, mission and values are clearly documented and underpin all planning decisions with the aim of ensuring coordinated service delivery to meet the needs of the residents. The business goals sighted for Aria Park Village include occupancy, staffing, quality improvements and development, risk analysis with continuous improvements identified, human resource management, infection control, health and safety, clinical and support services. Quality data is reported at organisational level monthly.</p> <p>On the day of the audit, the service had 73 residents; 34 rest home level care and 39 hospital level care. One hospital level care resident resides in the attached village under an Occupation Right Agreement (ORA) with a dedicated staff member 24 hours, seven days a week. (A letter of dispensation was sighted from the Ministry of Health dated 23 September 2013).</p> <p>Two rest home level care residents who also have an ORA, live in the studio units attached to the care facility. One rest home level care resident is under the age of</p> |

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|   |           | <p>65 years of age as identified in their district health board contract.</p> <p>The overall responsibility for the day to day running of the facility is undertaken by the village manager who has many years' experience in health management. He has been in the role for 10 months. He is supported by the clinical manager, who has been in the role for 8 months. She is a registered nurse with a current practising certificate. She has worked in aged care for over 15 years, 11 of these years have been in management positions. There is a team of nine other registered nurses, who all hold interRAI competencies. Staff and management attend relevant education according to the roles they undertake.</p> <p>Accountability and responsibilities are clearly described in the job descriptions sighted.</p>  |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>Aria Park Village has a quality and risk management system which is understood and implemented by service providers. This includes the update of policies and procedures, regular internal audits, incident and accident reporting, health and safety reporting, infection control data collection and management, and restraint management. If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective action plans are developed and overseen by the quality group which consists of senior staff from each service area. A discussion was undertaken at the time of audit related to the internal evaluation process. Whilst this is documented it is sometimes not clear what measures are used to evaluate the improvement put in place. Management agreed that moving forward they will show this more clearly.</p> <p>Quality related information is shared with all staff via the handover process on each shift and/or during the staff meetings. This is verified during staff interviews and in documentation sighted. Monthly reporting at organisational level is undertaken electronically and clearly documented by the village manager.</p> <p>The policies and procedures reflect legislative and good practice requirements. There is a system in place at head office to ensure they are kept up to date. Aria Park Village is in transition from the use of the previous provider's policies and procedures. They are being updated and reviewed to meet Arvida Care and Wellbeing protocols and procedures.</p> <p>Quality data collected is trended against previously collated data with head office undertaking a full annual review. This is linked to the quality and risk management system and is used to highlight both positive and negative findings. Day to day analysis of data is monitored by the village manager. Benchmarking occurs with</p> |

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|   |        | <p>other aged care services in the organisation.</p> <p>Staff, resident and family/whanau interviews confirmed any concerns they have are addressed by management. Staff gave many examples of quality improvements made since the new service providers have owned this facility.</p> <p>Actual and potential risks are identified using the quality and risk planning processes. Any newly identified hazards are discussed, monitored and managed via the health and safety processes in place. Staff confirmed that they understand the implemented hazard identification processes. The hazard register reviewed is due to be updated in January 2017. The village manager stated that this process is diarised and will occur via the quality group.</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 and where appropriate their family/whānau of choice in an open manner.</p> | FA     | <p>Adverse event reporting, as identified in policy, is implemented by the service. The clinical manager and village manager confirmed their awareness of the organisation's requirement related to statutory and/or regulatory obligations including the need to report pressure injuries under section 31 of the Safety Act 2016. Reporting forms are included in the policy manual reviewed.</p> <p>Staff interviewed stated that they report and record all incidents and accidents and that this information, along with any corrective action requests, is shared at the staff meetings. This was confirmed in minutes of meetings sighted. The corrective action process is overseen by the quality group.</p> <p>Residents' records reviewed included incident and accident forms. The forms sighted identified that all issues reported had corrective actions in place when required. Information is entered electronically and shared at organisational level. The clinical manager confirmed that the general manager of wellness and care would be notified of any serious adverse event. Family/whanau notification is clearly written in documentation and confirmed during family/whanau interviews.</p> <p>Management interviewed reported that information gathered from incident and/or accident forms are used as an opportunity to improve services as required or indicated. One example related to the increased use of senior mats as a method of falls prevention.</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>   | PA Low | <p>Human resources management processes are conducted in accordance with good employment practices and meet legislative requirements. The service appoints appropriate service providers to meet the needs of the residents. Processes are clearly identified in the policies and procedures sighted.</p>   |

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|   |           | <p>Staff records showed that all roles have job descriptions that describe staff responsibilities and accountabilities. Newly appointed staff are required to complete an induction handbook along with specific competencies for their roles and this covers all essential components of service provided. Currently staff are given a three-month period to complete all aspects of orientation. Documentation in the staff records reviewed confirmed some competencies, such as medication management, restraint and infection control, are reviewed annually.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking and police checks.</p> <p>The education programme sighted for 2016/2017 identifies that staff undertake training and education related to the roles they undertake. Topics covered in the annual training and education relate to aged care and health care services. Members of the management team also attend training and seminars specific to management related topics. Education occurs both on and off site.</p> <p>Residents and family/whanau members interviewed, identified that the service meets residents' needs.</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 process in policy which determines service staffing levels and skill mix for the services provided. Staff confirmed during interview that the rostered numbers of staff change according to residents' needs. Staff numbers sighted on four weeks of rosters showed that core staffing is maintained to meet residents' needs and to comply with contractual requirements.</p> <p>Rosters identify that staff are replaced for sickness and annual leave. The service has a pool of experienced casual staff which includes one RN.</p> <p>Staff reported they had adequate time to complete the required tasks to meet residents' needs. There are registered nurses on duty for all shifts. There is an on-call system for clinical advice and support after-hours. On the day of audit it could not be confirmed that every shift had a staff member who held a current first aid certificate. This information was obtained via email the day following audit from the off-site contractor who took the staff through first aid education in September 2015. When compared to roster information it shows that all shifts are covered by an existing staff member who hold a current first aid certificate.</p> <p>Resident and family/whanau members interviewed stated all their needs have been met in a timely manner.</p> |

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| <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 medicine management policy is current and identifies all aspects of medicine management in line 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 roles and responsibilities related to each stage of medicine management. All staff who administer medications are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the pharmacist and the registered nurses against the prescription. All medications sighted are within the current use by dates. Clinical pharmacist input is provided on a regular basis and six monthly audits are performed. The GP interviewed has no concerns about medication management at the facility.</p> <p>Controlled drugs are stored in the hospital in a secure manner in accordance with requirements. Two registered nurses check controlled drugs weekly. The controlled drug register provided evidence of the routine checks and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridges and the medication room reviewed are within the normal range.</p> <p>The GP prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for as required (pro-re-nata (PRN)) medicines are met. The registered nurses monitor PRN usage and advise the GP as required for an individual resident.</p> <p>There are two residents who self-administer medications. There is a process for staff to follow and the GP has to verify that the resident is competent to self-administer. This status is reviewed regularly by the GP and RN. There is a process for any medication errors and compliance with this process was verified.</p> <p>No standing orders were in use during the audit.</p> |
| <p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of</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. The main cook has recently resigned and the assistant cook is now cooking full time until the main cook position is filled. The menu follows summer and winter patterns and has been</p>  |

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| <p>service delivery.</p>  |           | <p>reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage transportation, delivery and disposal comply with current legislation and guidelines. The service has an additional cleaning schedule for daily chores to be completed. Food temperatures, including high risk items, are monitored appropriately by the cook and recorded accurately. The acting cook and the kitchen hands have completed safe food handling training.</p> <p>A nutritional assessment is undertaken on admission to the facility and a dietary profile is completed by the registered nurses. The personal food preferences, and special diets and modified textured requirements are made known to kitchen staff and accommodated in the daily meal plan. Special diets and/or requirements are documented on the whiteboard in the kitchen. Special equipment to meet nutritional needs is organised on request.</p> <p>Evidence of satisfaction with meals was verified by family interviews and some responses from satisfaction surveys sighted. Residents were seen to be given sufficient time to eat their meal and those requiring assistance had this provided. There is sufficient staff on duty in the dining room at mealtimes to ensure assistance is available to residents as needed.</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 desired outcomes.</p>  | <p>FA</p> | <p>Documentation, observations and interviews verified that provision of care provided to residents is consistent with their identified needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service delivery. The GP interviewed verified that medical input is sought in a timely manner that medical orders are followed, and care is managed effectively. Care staff confirmed that care is provided as outlined in the documentation. A range of equipment and resources is available, suited to the level of care provided in accordance with the residents' needs.</p>   |
| <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> | <p>FA</p> | <p>The activities programme is provided by two activities co-ordinators. One is responsible for the hospital level residents and has been in the role for one year and the other is a qualified diversional therapist who is awaiting the final 'sing off' of the training programme, and has been in the role for three months. This co-ordinator is responsible for the rest home level residents. The activities co-ordinators work together to plan the programme. The programme is displayed on all notice boards around the facility and the residents get a copy of the weekly plan. Activities were observed in both the rest home and the hospital and residents were seen to be enjoying themselves and participating in the activities.</p>  |

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|   |    | <p>A van outing was observed in the afternoon on the day of the audit and residents had enjoyed the community outing.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. The programme sighted is based on activities that will be meaningful to the residents. The activities plans are reviewed six monthly. Residents and family interviewed confirmed they find the programme interesting and enjoyable. Family can visit and participate whenever they choose.</p>  |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | FA | <p>Resident care is evaluated on each shift and reported in the progress records. If any change is noted, it is reported to the registered nurse.</p> <p>Formal care plan evaluations, occur six monthly in conjunction with the six monthly interRAI reassessment or as the residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the long term care plan. Examples of pre-populated short term care plans were consistently reviewed for wound care, continence review, falls prevention and management, and evaluated at the clinically indicated timeframe stated on the plan (eg, daily or weekly) and according to the degree of risk noted during the assessment process.</p> <p>Families/whanau interviewed provided examples of involvement in evaluation and any resulting changes. The family communication record sheets are in each resident's record sighted and evidenced that family are notified for any changes or new events.</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>                              | FA | <p>The service undertakes all processes to ensure the building warrant of fitness can be maintained. The current building warrant of fitness expires on 23 December 2017.</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>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the infection register. The infection control coordinator (ICC) reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions.</p>   |



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|  |           | <p>Results of surveillance are shared with staff via the staff meetings and at staff handovers. Early interventions are encouraged by the registered nurses. The care staff interviewed are aware of who to report to should they suspect any signs or symptoms of infection when caring for the residents.</p> <p>The organisation also belongs to an external infection prevention and control group for advice and reference material is available to guide staff. The organisation is currently not benchmarking infection surveillance with their other facilities, but this is acknowledged as being a quality improvement objective for 2017.</p>  |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | <p>FA</p> | <p>The service restraint minimisation and safe practice policy meets the requirements of the standard. Clear definitions of an enabler and a restraint are available to guide staff.</p> <p>On the days of the audit the register reviewed listed five residents using an enabler (4 bedside rails and one lap belt) and 14 residents using a form of restraint (13 bedside rails and three lap belts). Two residents have two types of approved restraint which brings the number of restraints in use to 16. Three resident records were reviewed for restraint and enabler use only and they contained evidence that assessment has been completed prior to restraint implementation. Approval is granted by the restraint committee for safety reason only. Signed consent forms were sighted. There was evidence of ongoing monitoring and review of each restraint intervention. Enabler use was voluntary to allow residents to remain as independent as possible.</p> <p>A discussion with the restraint coordinator (RN) was held about ways in which the service plans to try to reduce restraint use. The clinical manager stated that this a goal for 2017 and that a project around this is to commence within the next two months.</p> <p>Feedback from staff was positive about training and knowledge on the service`s restraint philosophy and approach to restraint minimisation. All processes are clearly understood.</p> |

## 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 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p> | PA Low            | <p>New service providers receive an orientation/induction programme and evidence is maintained in a specific booklet. This covers all the essential components of service related to the staff member’s role. The staff annual appraisals are not up to date. The village manager is aware of this and has a process in place to correct this.</p> | <p>No staff annual appraisals have been completed since 2015.</p> | <p>Provide evidence that staff annual appraisals are up to date.</p> <p>180 days</p> |

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

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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.