

# Matamata Country Lodge 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:

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| <b>Legal entity:</b>  | Matamata Country Lodge Limited   |
| <b>Premises audited:</b>  | Matamata Country Lodge   |
| <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: 31 January 2017      End date: 31 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> | 81   |

# 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   |
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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         |

| 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

Matamata Country Lodge continues to provide hospital and rest home level care. In December 2016, the service was reconfigured by adding two rest home beds and one dual purpose bed to bring the total capacity from 96 to 99 beds. The location and fit out of these additional bedrooms was included in the site tour.

This unannounced surveillance audit was conducted against a sub-set of the relevant standards and the contract with the district health board (DHB). The audit process included review of policy and procedures, the review of resident and staff files, observations and interviews with residents, management and staff. The residents and family members interviewed, talked positively about their experiences with the service and expressed confidence in the quality and extent of care provided. A general practitioner interviewed by telephone stated the service and its staff provided excellent care.

Each of the standards assessed met the requirements, and two areas (food and medicines), demonstrated achievement above the requirements.

## 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. |
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The service adheres to the principles and practices of open disclosure when dealing with unwanted events.

All verbal and written complaints received by the service in the past 16 months have been responded to and investigated in a timely and open manner. Residents said they knew how to make a complaint and that they were entitled to support during the process. There had been no known complaints investigated by the office of the Health and Disability Commissioner. The complaints system is fair and effective.

## 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. |
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The service is maintaining its commitment to continual quality improvement. The quality and risk management systems met the standard required. Any areas of concern in service delivery were being promptly identified and actions to remedy the problem are initiated. Information and methods which monitor the quality of the services provided are consistently reviewed and improved upon.

All adverse events were being reported and investigated. Two events have been notified to the DHB and the Ministry of Health since the previous certification audit.

Staff are well managed according to policy and good employer practices. New staff are recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new

staff. Ongoing staff education is planned and coordinated to ensure that staff receive relevant and timely training on subjects related to care of older people. Training is occurring regularly through in-service education sessions, via self-directed learning and presentations by external experts. Staff competency assessments are occurring regularly.

There are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week, to meet the needs of residents requiring hospital and rest home level care. Registered nurses (RNs) are on site seven days a week and on call 24 hours a day.

## 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 service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision, evaluation, review and exit are provided within time frames that safely meet the needs of the resident and contractual requirements.

All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs a short term plan is developed and integrated into a long term plan, as needed. All care plans are evaluated at least six monthly.

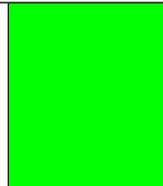
The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes accommodated. The service has a five week rotating menu which is approved by a registered dietitian. Resident's nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## Safe and appropriate environment

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

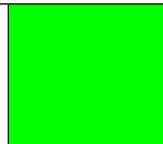


Standards applicable to this service fully attained.

There is a current building warrant of fitness. There have been no changes to the external structure of the building that required a building consent or amendment to the fire evacuation scheme. Three new bedrooms and a purpose built central laundry space have been completed since the previous audit. The buildings, plant or equipment and external areas are of a high standard and are being well maintained.

## 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.

The service uses best known processes for determining safe and appropriate restraint and enabler use. On the day of audit the restraint register was up to date with those residents who required interventions to maintain their safety. The methods used for assessment, consent and approval, monitoring, evaluation and review meet all the requirements of the Restraint Minimisation and Safe Practice Standards.

## 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 completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are benchmarked and reported back to staff and residents, where appropriate, 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) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 16                  | 0  | 0                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 2                           | 36                  | 0  | 0                                    | 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:<br/>Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p> | FA                | <p>The service continues to effectively manage its complaints process and maintain the complaints register. Residents confirmed knowledge of the ways to lodge a complaint. Review of the complaints register and interview with the nurse manager revealed that each of the complaints received since the previous audit had been acknowledged and openly addressed, thoroughly investigated and resolved in a timely manner with all parties. The records show there was ongoing communication with the people involved and all issues have been resolved.</p>  |
| <p>Standard 1.1.9:<br/>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>          | FA                | <p>The organisation is adhering to the principles of open disclosure and the procedures within their policy. Review of information related to incident/accident reports and complaints received reveal the ways in which the organisation attends to the rights of residents and their families to know what has happened to them and to be fully informed. Evidence of notification to families and the GP was seen in accident/incident forms and in the residents' progress notes.</p> <p>There are no residents who currently require interpreter services. Staff advised that family members have interpreted for residents in the past and prompt cards are used for residents with difficulty in communicating, with</p> |

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| conducive to effective communication.   |    | support from external services, such as the local hearing association, when required.  |
| <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>There have been no changes to the ownership or governance since the previous certification audit. The Cantabria Group continue to provide aged care across three sites including Matamata Country Lodge. The three nurse managers from each facility meet regularly with the owners and benchmark service outputs, review the quality and risk systems and provide support to each other. On the day of this audit there were 81 residents on site. Fifty five of these were assessed as requiring rest home level care and 26 as requiring hospital care. One resident was under the age of 65 years.</p> <p>The organisation's vision, mission, values and annual goals are in the current business plan which is reviewed regularly by the group.</p> <p>The nurse manager has a current practising certificate with the Nursing Council of NZ and is maintaining her nursing portfolio and meeting the contractual requirements by attending on going education in clinical and management topics.</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> | FA | <p>The organisation is maintaining effective quality and risk management systems. There is monthly benchmarking of the frequency and type of accidents/incidents and infections across the three aged care facilities. Quality improvements are documented for action and completion whenever a service deficit is identified via internal audit, or as a result of analysing quality data or feedback. Residents and family feedback is sought regularly via surveys and meetings. A residents' meeting was observed during audit day.</p> <p>Policies and procedures are reviewed annually and updated as required to meet known best practice. All quality data continues to be analysed and discussed at the nurse managers' meetings and at various facility staff meetings. There is documented evidence of corrective actions on incident/accident reports, on the internal audit tools where a deficit or gap is identified, in the hazards register, and in complaints documentation.</p> <p>The organisation's annual business plan, quality and risk plan and associated emergency plans identify all actual and potential risk to the business, service delivery, staff and/or visitor's health and safety. Environmental risks are communicated to visitors, staff and residents as required through notices, or verbally, depending on the nature of the risk</p> <p>The service is maintaining a focus on health and safety. A recent initiative has all Health and Safety Committee members wearing a badge identifying them as Health &amp; Safety members. This was introduced to raise the profile of Health and Safety on the floor, on a daily basis. Staff have found this initiative gives them support for interventions if required and an identified 'go to' person for staff, family, visitors to approach. Minutes from the Health and Safety meeting in July 2016 show that staff say it has definitely raised the profile. The facility has a secondary level workplace safety management plan and there is a low rate of staff injury. At risk residents are identified through</p> |

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|   |    | <p>analysis of incident data (for example falls, infections, skin tears and other known factors such as confusion). Contingencies to prevent or minimise injury to 'at risk' residents is discussed at RN meetings and actions are agreed and initiated. The hazard register and risk management plan are being kept updated. Staff interviewed confirmed knowledge of and participation in quality and risk management processes.</p>  |
| <p>Standard 1.2.4:<br/>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>The adverse event reporting system was known by staff interviewed and is co-ordinated by a senior RN with review from the clinical nurse leader and nurse manager. The event records showed that reporting occurs immediately and is investigated to determine cause and prevent or minimise recurrence. All people impacted by the adverse event are notified. The manager advised there had been two events requiring external notification since the previous audit. One was related to resident injury and the other was a police matter.</p>  |
| <p>Standard 1.2.7:<br/>Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>   | FA | <p>Interviews and records confirmed that staff are effectively recruited and managed. The skills and knowledge required is documented in position descriptions and employment agreements. The nurse manager and a cross section of staff confirmed they understand their roles, delegated authority and responsibilities. Every job applicant is reference checked and police checked. The six staff records reviewed, contained evidence of curriculum vitae (CVs), educational achievements, and copies of current practising certificates where applicable</p> <p>New staff are oriented to organisational systems, quality and risk, the Code of Rights, health and safety, resident care, privacy and confidentiality, restraint practices, infection prevention and control and emergency situations by the staff education and development officer.</p> <p>Staff maintain knowledge and skills in emergency management, first aid certificates and competencies in medicine administration and attend regular training. The service is encouraging and supporting health care assistants (HCAs) to achieve the level three NZ certificate in Health and Wellbeing. 45% of care assistants already have educational achievement in care of older people and it is a goal of the service that 100% attain a level 3 qualification.</p> |

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| <p>Standard 1.2.8:<br/>Service Provider<br/>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>    | <p>FA</p> | <p>Rosters sighted, and interviews with all levels of staff, residents and families confirmed that there is an appropriate number of staff on site at all times. RNs are available on site with more on call 24 hours a day seven days a week. Residents are satisfied with the responsiveness of staff.</p>   |
| <p>Standard 1.3.12:<br/>Medicine<br/>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 registered nurse described the processes to ensure safe administration of all medications. This included competency requirements, prescribing, recording, the process when an error occurs, as well as definitions for 'over the counter' medications that may be required by residents. At the time of audit one resident was self-administering medications and this was in the resident's room in a secure location.</p> <p>Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in a medicine trolley individually in the treatment rooms which are locked when not occupied. A locked cupboard is used for controlled medications and the medicine register was sighted. Medications that require refrigeration are stored in a separate fridge with recorded temperatures documented.</p> <p>The facility has implemented an electronic medication charting and management system. The 16 medicine charts sighted have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and 'as required' (PRN) medications identified had the reason stated for the use of that medication. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident.</p> <p>There are documented competencies sighted for all staff responsible for medicine management. The registered nurse administering medicines at the time of audit demonstrated competency related to medicine management.</p> |
| <p>Standard 1.3.13:<br/>Nutrition, Safe Food,<br/>And Fluid<br/>Management</p> <p>A consumer's</p>   | <p>FA</p> | <p>Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and meet the food safe requirements. The kitchen supervisor/chef interviewed had a very good understanding of food safety management and have completed ongoing updated food safety training.</p>   |

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| <p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>  |           | <p>There is a five week rotating menu that has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.</p> <p>A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.</p> <p>The kitchen also offers residents a variety of cereals for breakfast, a main option for lunch including a desert and a lighter menu option for dinner also supporting individual residents with different cultural food needs if required. All main meals are supported by morning and afternoon tea which includes home baking.</p> <p>All meals are cooked from the onsite kitchen, food is transported by transport boxes, lunch and dinner is served in one of three dining rooms with residents having breakfast in their bedrooms. Residents have the option of trays in their rooms throughout the day, however all residents are encouraged to have their meals in the dining rooms to encourage appetites and socialisation.</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>Clinical management policies and procedures on admission include assessments of weight, mobility, ability and/or support required for residents to complete daily activities of living, clinical notes and referral information.</p> <p>As observed on the days of the audit, the clinical nurse leaders and care staff demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident's care plan. The residents' files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.</p> <p>The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident's assessed needs and desired goals. The clinical nurse leaders and care staff interviewed reported they have input into residents' care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident's 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</p>                              | <p>FA</p> | <p>The activities programme uses a framework to empower the residents both young and older to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities staff adapts activities to meet the needs and preference of choices/cultural preferences of the aged care residents.</p> <p>The facility has one diversional therapist and an activity co-ordinator (currently training to be a diversional therapist) who both work Monday – Friday (0830-1630), who are supported by an external meeting group/newsletters. The</p>  |

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| <p>appropriate to their needs, age, culture, and the setting of the service.</p>   |           | <p>weekly activities plan/calendar sighted was developed based on the resident's individual needs and interests and can be easily adapted and changed depending on the resident's physical ability, interest and reaction at the time. The activities staff advertises the upcoming activities on the calendar by providing this to residents on the notice board in the facility. The activity staff visit all the residents each morning to encourage them to partake in the day's activities. Regular activities include daily newspaper reading and different types of exercises, scooter group, church services, regular visiting entertainment and regular trips out with the support of the facility van. The residents also partake in regular community activities such as shopping, Bridge, a church friendship club. Residents have also facilitated regular activities/groups on the weekends. There are also specific men and lady's activities/outings, a newsletter which is created every other month and bi-monthly resident meetings. All public holidays and special events are celebrated. For residents who wish to remain in their rooms, activities and one to one interaction is offered and supported by staff. The care staff interviewed stated that they have access to activities to support residents after hours and on the weekends. Staff throughout the day continue to promote social interaction by inviting and encouraging all residents to join in activities together in the main lounges.</p> <p>The residents' files reviewed have activities and social assessments that identify the resident's individual diversional, motivational and recreational requirements. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident's file three monthly.</p> <p>All residents and families interviewed stated that they were happy with the activities on offer and families and visitors felt included when they visited.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>The eight residents' files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.</p> <p>Residents' changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or who are not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans were sighted for wound care, infections, changes in mobility, food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents' progress notes. The care staff interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.</p> <p>Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident's condition.</p>   |
| <p>Standard 1.4.2:</p>   | <p>FA</p> | <p>There is a current building of warrant of fitness. Plant and equipment is checked and maintained as required by</p>  |

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| <p>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>  |           | <p>legislation, regulations and standards. Hazard reporting/monitoring, reactive and preventative maintenance occurs. All external areas are safe. Three additional bedrooms and a central laundry have been created since the previous audit. This has not required a new fire evacuation as the footprint of the building has not changed. Each of the bedrooms are generous in size, have ensuite bathrooms and are located close to common areas. They are suitably furnished and the building materials and chattels provided are of a high standard. A resident who occupies one of the rooms and their family member expressed satisfaction. The new laundry replaces two separate laundries. Processes still allow for separation of laundry for hospital and rest home. The equipment is new and has the capacity to meet demand.</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> | <p>FA</p> | <p>All staff are required to take responsibility for surveillance activities. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents' safety. The infection coordinator completes a monthly surveillance report. The service monitors skin and soft tissue wounds, pressure injuries, urinary tract infections, oral, eyes, ear, and gastroenteritis infections. Antibiotic use is also monitored. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections and data is benchmarked externally. This information is fed back and discussed in management, staff and where appropriate, family and resident meetings.</p> <p>The monthly reports identify two residents who are chronically unwell and frequently require antibiotics. Short term and long term care plans sighted evidence interventions in place to reduce and minimise the risk of infection.</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>There are ten residents in the hospital wing who are using bedrails and lap belts. Nine of these are recorded in the register as restraints and one bedrail as a voluntary enabler. Interview with the spouse of a resident with bedrails and lap belt in daily use, confirmed these were agreed too and necessary for the person's safety. Information had been provided to the family and was ongoing, especially during six monthly reviews or when change was required. Restraint activity is reported monthly and the restraint approval group meets every six months to review and evaluate restraint matters and staff education needs. The service meets the requirements of this standard.</p>   |

## Specific results for criterion where corrective actions are required

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

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

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

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

| Criterion with desired outcome   | Attainment Rating | Audit Evidence  | Audit Finding  |
|--|-------------------|---|--|
| <p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p> | CI                | <p>In May of 2016, the service reviewed medication errors as a medication audit showed evidence of one medication error per month. The service introduced an electronic charting and management system in July 2016 and since its implementation audit findings have shown a reduction in and a total of three errors as at the end of December 2016. The senior nurse leader was given the role of champion for the new medication management system which included staff training and associated competencies. The champion role also includes the reviewing of electronic data on a weekly basis which is then discussed at management and staff meetings.</p> | <p>The service is rated continuous improvement evidencing a reduction in medication errors by fifty percent and showing evidence of 100 percent compliance with staff medication competencies and medication administration in monthly audits.</p> |

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| <p>Criterion 1.3.13.1<br/>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p> | <p>CI</p> | <p>The family satisfaction questionnaire completed 6 July 2016 seeking resident feedback on each midday and evening meal indicated that there was an area for improvement. Of the 32 forms returned, seven families said 'our meals were only fair, eleven said good, eight said very good'. One formal complaint was received. The service initiated daily checking of food before it left the kitchen and prior to presentation in the resident's dining room. Photos of food were also taken to support food presentation and staff education. Four surveys have been completed between the months of September and December 2016 showing that there was an increase in resident's food satisfaction and improvements made and that residents are 'enjoying the meals again'. Evidence of discussion and positive feedback was also seen in residents' meetings. The resident and their family who made the formal complaint have also reiterated that the meals have improved. The family survey is due to be repeated in June 2017.</p> | <p>The service is rated continuous improvement by demonstrating positive outcomes provided by residents and family in feedback forms, residents' meetings and no further complaints as at the end of December 2016 in relation to the food service.</p> |
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End of the report.