

Masonic Care Limited - Woburn

Introduction

This report records the results of a Partial Provisional and 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:

Legal entity:	Masonic Care Limited
Premises audited:	Woburn Masonic Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 February 2017 End date: 15 February 2017
Proposed changes to current services (if any):	To change the current 24 rest home beds to dual purpose beds, so that all 58 beds can be used as dual purpose.
Total beds occupied across all premises included in the audit on the first day of the audit:	54



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

Woburn Masonic Care provides residential care for up to 58 residents who require rest home and hospital level care. On the first day of audit there were 54 beds occupied. The facility is operated by Masonic Care Limited.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a general practitioner. A partial provisional audit was also undertaken to establish the level of preparedness of the provider to change 24 rest home beds to be also available for hospital level care (dual purpose beds) making the total number of beds dual purpose.

Areas of improvement have been identified relating to quality data reported back to staff, performance appraisals, orientation documentation for new staff, in-service education, timeframes in which the general practitioner reviews residents, aspects of medicine management and hot water in resident areas exceeding the required temperature.

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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Information regarding residents' rights, access to interpreter services and how to lodge a complaint is available to residents and their families. The complaints register is current and all complaints have been entered. Residents and their families reported their satisfaction with the open communication with staff. One investigation has been completed by District Health Board since the previous audit. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Masonic Care Limited is the governing body and is responsible for the service provided. A business plan and a quality and risk management plan that documents scope, direction, goals, values, and a mission statement is in place. There is regular reporting by the facility manager to the chief executive officer (CEO) who reports to the board.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The manager is supported by two charge nurses who are responsible for the clinical service.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Registered nurses, clinical, management, health and safety and residents' meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

There are policies and procedures on human resources management. Staff have the required qualifications.

The documented rationale for determining staffing levels and skill mixes is based on best practice.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents' needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff (podiatrist; physiotherapist; pharmacist) and a designated general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrate that needs, goals and outcomes are identified. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by two diversional therapists, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed using a manual system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food control plan and policies guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

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 medium or high risk and/or unattained and of low risk.
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Building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

It is proposed that 24 rest home bedrooms will provide either rest home level care or hospital level care (dual purpose bedrooms). Four rest home bedrooms have already been approved to provide dual purpose accommodation and share full ensuites. The rest of the rooms are single and have ensuites consisting of a toilet and wash hand basin. Six of the 18 rest home care rooms are large enough to provide both hospital or rest home accommodation and allow for residents and staff to safely move around in them and for the use of equipment. There are adequate toilet and shower facilities throughout the facility.

Residents have access to several lounge areas and dining rooms. An appropriate call system is available and security systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. Personal laundry is washed on site and bed linen by an external contractor. Cleaning and laundry systems are audited for effectiveness.

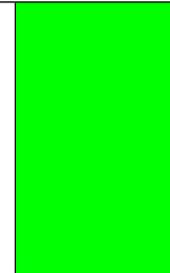
Restraint minimisation and safe practice

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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Policies and procedures for restraint minimisation and safe practice are in place. There are currently no residents using restraints or enablers.

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.

The service provides a managed environment that minimises the risk of infection. The infection prevention and control programme is led by an experienced infection control coordinator. Specialist infection prevention and control advice is able to be accessed from the District Health Board. The programme is reviewed annually.

Aged care specific infection surveillance is undertaken, analysed, trended and benchmarked. Results are reported through all levels of the organisation. Follow-up action is taken as and when required.

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	20	0	3	2	0	0
Criteria	0	52	0	5	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available within the facility. All resident rooms have an information booklet in a special container on the wall that includes how to make a complaint and a copy of the Code.</p> <p>The complaints register showed 15 complaints were received during 2016 and one complaint this year. Documentation was complete for all the complaints and Right 10 of the Code had been followed.</p> <p>The facility manager is responsible for the management and follow up of complaints. Staff interviewed confirmed a good understanding of the complaint process and what actions are required.</p> <p>The facility manager (FM) reported there has been one investigation by the District Health Board since the last audit relating to care and communication. Documentation reviewed evidenced this complaint has been investigated and closed out. The FM advised there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</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>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Interpreter services can be accessed when required. Staff knew how to do so, although reported this was rarely required due to all present residents' ability to speak English.</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>Masonic Care Limited is governed by a board of trustees who meet throughout the year. A strategic plan 2016-2021 includes a purpose, vision, mission, values and operational development. The FM reports to the chief executive officer (CEO) monthly and the CEO presents a combined report to the board which includes a wide range of subjects including facility performance, care reporting, HDC investigations and sector issues. There are also three monthly meetings of all the facilities in the group. Review of reports and interview of the facility manager confirmed this. The FM advised the CEO is based at the facility, so that support is near-by if required.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service.</p> <p>The FM, who is a registered nurse, has 16 years' experience in their present position. The FM is supported by two charge nurses, one was unavailable on audit days, the other has been in their position for 16 years. Interview of the FM and the charge nurse and review of their personal files evidenced they have undertaken on-going education in relevant areas.</p> <p>Woburn is certified to provide hospital and rest home level care. On the first day of this audit there were 23 hospital level care residents and 31 rest home level care residents.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the facility manager, the charge nurses deputises. When a charge nurse is absent, the FM or other charge nurse takes responsibility for clinical overview. The FM and charge nurse confirmed their responsibility and authority for these roles.</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>PA Low</p>	<p>A quality and risk management plan guides the quality programme and included goals and objectives. An internal audit programme is in place and completed internal audits were reviewed. Registered nurse, clinical, management, health and safety are held monthly and resident's meetings three monthly. Meeting minutes reviewed confirmed this. Review of staff meeting minutes evidenced staff meeting have not been held in the past two years. Interview of the FM and care staff confirmed this. Care staff also stated they do not receive results of quality improvement data. Registered nurses reported they discuss clinical indicators at their meetings, however there was no documented evidence of reporting and discussion of analysis to identify trends.</p> <p>A resident/family meeting is held annually, the last one was in February 2016. The FM advised this has replaced the satisfaction survey and has been more successful than sending out a survey. Minutes of meetings indicated residents and family are satisfied to very satisfied with the services provided.</p> <p>Completed audits for 2016 and 2017, clinical indicators and quality improvement data were reviewed. Review of the quality improvement data evidenced data is being collected and collated. Corrective actions were consistently developed and implemented. There was documented evidence of follow-up to the action taken and the effectiveness. There was evidence of graphing of clinical indicators and benchmarking three monthly by an external agency.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures have been reviewed and are current. Staff confirmed they are advised of updated policies and that the policies and procedures provide appropriate guidance for service delivery. The assessment and re-assessment policies include interRAI requirements.</p> <p>Actual and potential risks are identified and documented in the hazard register, including risks associated with human resources management, legislative</p>

		<p>compliance, contractual risks and clinical risk and showed the actions put in place to minimise or eliminate risks. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and implemented documented hazard identification processes.</p>
<p>Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. The charge nurse reviews these. The original is kept in the residents' files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events.</p> <p>There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>The FM stated they are aware of essential notification reporting to external agencies. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting.</p>
<p>Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Moderate	<p>There are human resources management policies and procedures. Staff files included job descriptions which outline accountability, responsibilities and authority, employment agreements and police vetting.</p> <p>The FM and charge nurse have taken responsibility for managing in-service education following the quality coordinator leaving employment. In-service education has been spasmodic over the last two years. Apart from continence management, manual handling and communication, core subjects have not been completed. The FM and charge nurse stated they are currently reviewing the in-service programme with a view to providing topics three times per year. Individual records of education are maintained.</p> <p>The FM advised a New Zealand Qualification Authority education programme will be introduced in the new year and staff have been enrolled to commence this.</p> <p>Registered nurses have attended external education and the charge nurse stated</p>

		<p>'tool box' talks occur at handover when there is a specific health event relating to a resident, and one to one training occurs. However, this has not been documented. Medication competencies were not current and there was no evidence of restraint competency assessments for clinical staff.</p> <p>There is an orientation/induction programme. The entire orientation process can take up to two months to complete. Orientation for staff covers the essential components of the service provided. Care staff confirmed they have completed an orientation, however, not all staff had an orientation on file. Five of the seven registered nurses have completed the interRAI assessment programme education.</p> <p>Not all staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.</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>	FA	<p>There is a documented rationale for determining staffing levels and skill mixes that is based on best practice. There are two RNs rostered on the morning and afternoon shifts. Eight caregivers are rostered on the morning shifts and six on the afternoon shifts. The minimum number of staff is provided during the night shift and consists of one RN and two caregivers. The FM and charge nurse stated they review the roster constantly and staff the facility as though all the residents are hospital level care. The FM is rostered on-call after hours. Care staff reported there are adequate staff available and that they can complete the work allocated to them. Residents and families reported there was enough staff on duty that provided them or their relative with adequate care. Review of rosters and observations during this audit confirmed staff cover is above requirements.</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>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of audit. The staff member observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Staff who administer medicines do not have current competent assessments. (See criterion 1.2.7.5)</p>

		<p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications were not verified as being checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. However, the required three monthly GP review of medication is not consistently recorded.</p> <p>There are no residents who self-administer medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the charge nurse and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.</p> <p>Standing orders are not used.</p> <p>With the exception of the corrective actions identified, there will be no changes required to the services medication management system with the addition of six additional hospital residents.</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 service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by an external contractor and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food control plan with registration issued by the Ministry of Primary Industries, September 2016. Food temperatures, including for</p>

		<p>high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. There will be no changes required to the service with the addition of six additional hospital residents.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, the annual resident and family satisfaction meetings and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their 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 provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a satisfactory standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and 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>	FA	<p>The activities programme is provided Monday to Saturday by two trained diversional therapists (DTs).</p> <p>A social assessment and history is undertaken over the first three weeks of admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as residents needs change and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents'</p>

		goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. The activities programme is discussed at the residents' recreation meeting, run by the DTs and indicated residents' input is sought and responded to. Residents meetings are held three monthly and run by the residents' advocate. Resident and family annual satisfaction meeting minutes demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme meets their requirements.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for infections and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets were sighted throughout the facility and accessible for staff. The hazard register is current. There was protective clothing and equipment in the sluice rooms and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a good understanding of processes relating to the management of waste and hazardous substances.

<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>	<p>PA Moderate</p>	<p>There is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Current electrical safety tags on electrical items were sighted. Documentation and observations evidenced a current Building Warrant of Fitness. Review of the hot water temperature recordings at resident outlets evidenced some outlets exceeding the recommended temperature. Interview of the maintenance person and review of documentation showed corrective actions have been implemented including several visits from the plumber to try and rectify the problem.</p> <p>Of the 24 rest home beds, 18 are small and the physical footprint is narrow. These rooms are not suitable as dual purpose bedrooms (room numbers 2, 4, 6, 8, 10, 12, 14, 15, 33 to 40, 42 and 44). The remaining six bedrooms are the same size as the 30 hospital level bedrooms and are suitable as dual purpose rooms. Although the doors are single width, the openings are wide enough and rooms large enough to allow equipment such as hoists, walkers and wheel chairs and care staff to safely manage residents. The six bedrooms have an ensuite consisting of a toilet and wash hand basin.</p> <p>Observations of the facility provided evidence of safe storage of equipment. Corridors are wide enough to allow residents to safely pass each other. Safety rails are secure and are appropriately located.</p> <p>External areas are available and these are maintained to an adequate standard and are appropriate to the residents. Residents are protected from risks associated with being outside, including provision of adequate and appropriate seating and shade, and ensuring a safe area is available for recreation or evacuation purposes.</p> <p>Care staff confirmed they have access to appropriate equipment, equipment is checked before use, and they are competent to use the equipment.</p> <p>Residents confirmed they know the processes to follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they can move freely around the facility and that the accommodation meets their needs.</p>
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<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of toilets and bathroom facilities throughout the facility. Residents and families reported that there are sufficient toilets and they are easy to access. Four bedrooms share a full ensuite and all other bedrooms have an ensuite consisting of a toilet and wash hand basin.</p> <p>Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All bedrooms are single, apart from one double which is used as a single room. There is space to allow residents to move safely around their personal space and bed. Rooms are large enough for additional chairs and furniture and are personalised with furnishings, photos, and other personal adornments. Staff were observed moving safely around the bedrooms. Corridors are wide enough and residents using mobility aids, visitors and staff can move past one another. Six of the 24 rest home beds are suitable for accommodating rest home or hospital level care residents. They are the same size as the existing hospital beds with adequate space for equipment and for care staff to move freely to care for residents safely.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are a good number of areas provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All resident's personal laundry is washed on site by the night staff. Residents and families reported the laundry is managed well and resident's clothes are returned in a timely manner. Other linen is laundered off site by an external contractor. The facility is cleaned to an adequate standard. The cleaner demonstrated good knowledge of cleaning processes. Residents and families stated the facility is kept clean. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external</p>

		company that supplies the chemicals.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is an approved fire evacuation plan. A policy on emergency and security situations covers all service groups at the facility. A fire drill takes place six-monthly. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the days of audit and all equipment had been checked within required timeframes.</p> <p>There is always at least one staff member on duty with a current first aid certificate. Staff files confirmed RNs have a current first aid certificate.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs. Back up lighting is available should there be a power outage.</p> <p>All bedrooms and communal areas have call bells to alert staff. Residents and families reported staff respond promptly to call bells. Audits of staff response to call bells are completed on a regular basis.</p> <p>Contractors must sign in and out of the facility. The external doors are locked in the evenings. A security firm completes checks during the night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heating is provided by hot water heaters. Residents are provided with safe ventilation and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable.</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 service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. A change in bed configuration by the service will not impact on the IPC programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level. The infection control programme and manual are reviewed</p>

		<p>annually.</p> <p>The facility manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the clinical team meeting. Infection data is entered into the quality performance system for analysis and benchmarking. Every three months the quality coordinators and facility managers of all the Masonic facilities meet with the General Manager and these meetings include discussion around infection related data.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</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 quality performance system and residents' clinical records. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via clinical team meetings and at staff handovers (refer 1.2.3.6) as confirmed in meeting minutes sighted and interviews with staff. Graphs are produced that identify trends for the current year, and comparisons against previous years. Data is benchmarked externally within the group and by an external benchmarking provider. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>Interviews verify new infections and any required management plans are discussed at handover to ensure early intervention occurs.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>At the time of audit there were no residents using restraint or enablers. A restraint register is available should it be required. The FM is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. Staff demonstrated knowledge about restraint processes and knew the difference</p>

		between restraints and enablers. The restraint coordinator and staff described how they have managed not using restraint through comprehensive assessments and review and the use of equipment such as sensor mats.
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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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Quality data is collected, collated, analysed and trends identified. Review of the clinical meetings evidenced discussions relating to analysis and trending. Although the RNs stated they do discuss data at their meetings, this was not documented in the minutes. Caregivers stated they do not receive any information relating to reporting back to them on quality indicators. Caregivers could not remember when they had last attended a staff meeting. Review of staff meeting minutes evidenced the last staff meeting was held in January 2015. The FM confirmed this.</p>	<p>Reporting of quality data at the RN meetings is not documented. Staff meetings have not been held since January 2015 and care staff reported they do not receive information or discuss collated data.</p>	<p>Provide documented evidence that: (i) the RN meeting minutes include reporting of quality data; (ii) Staff meetings are held on a regular basis including reporting of quality data to staff and this is documented in the minutes.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the</p>	PA Low	<p>Staff files reviewed provided evidence of job descriptions which outline accountability, responsibilities and authority, employment</p>	<p>Four of the seven staff files reviewed do not have a current performance</p>	<p>Provide evidence that all staff have a current performance appraisal.</p>

needs of consumers.		agreements, reference checks and police vetting. Practising certificates are current for all employees and contractors who require them. Although staff interviewed stated they have a current performance appraisal, four of the seven staff files reviewed do not have a current performance appraisal.	appraisal.	180 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	There is an orientation/induction programme and all new staff are required to complete this prior to their commencement of care to residents. Orientation covers the essential components of the service provided and staff can have up to two months to complete this. Although staff confirmed they have completed an orientation, not all staff have evidence of an orientation on file.	Three of the seven staff files reviewed did not have evidence that an orientation had been completed.	<p>Provide documented evidence that all staff have a completed orientation on file.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	In-service education has not been consistent over the last two years. Apart from continence management, manual handling and communication, core subjects have not been provided. There is evidence that the RNs attend external education. The FM and charge nurse stated they are currently reviewing the in-service programme with a view to providing three to four hourly study sessions three times per year. Individual records of education are maintained. The FM stated these have been recreated because this information was noticed to be missing off the staff files. Medicine education was provided last year, however, competency assessments for	In-service education for staff has been inconsistent over the last two years and required subjects have not been provided to staff on a regular basis.	<p>Provide documented evidence of an in-service programme that includes all required topics, and in-service education sessions are provided for staff on a regular basis.</p> <p>90 days</p>

		medicine management are not current and there was no evidence that clinical staff have competency assessments for restraint. Interviews of the FM and staff confirmed this.		
<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>	PA Low	<p>Medications are provided by the pharmacy in a pre-packaged format, however there is no evidence to verify the RN has checked the accuracy of the dispensed medications with the prescription. Interviews verified staff were unsure whether this was occurring.</p> <p>Seven of 12 medication charts reviewed had no evidence to verify the GP had reviewed the medications three monthly.</p>	Medicines management does not verify evidence of medicine reconciliation and three monthly medication reviews.	<p>There is evidence that GPs review residents' medications three monthly. There is a process for reconciliation of residents' medication implemented.</p> <p>180 days</p>
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are competent to perform the function.</p>	PA Low	<p>Medical assessment by the GP occurs within 48 hours of admission. Residents are reviewed either if their condition changes, monthly, or three monthly if the GP has deemed the resident stable and appropriate to be reviewed three monthly. Three of seven residents' files reviewed, are not being reviewed by the GP within the required timeframes. Evidence sighted supports the resident being stable at this time. Interviews and documentation verifies GP input is accessed when residents are unwell.</p>	Residents are not always reviewed either monthly or three monthly as per the required timeframes.	<p>Evidence is provided to verify the GP reviews residents within the required timeframes.</p> <p>180 days</p>
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment</p>	PA Moderate	A current building warrant of fitness is displayed that expires on the 6 June 2017.	Recordings of hot water temperatures at several	Provide documented evidence that hot water

<p>comply with legislation.</p>		<p>There is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Testing and tagging of electrical equipment is current. Recordings of hot water temperatures to several resident outlets showed they exceed the recommended temperature, some as high as 57 degrees Celsius. The maintenance person interviewed and documentation reviewed evidenced the plumber has been called several times to try and rectify the problem. The maintenance person stated the temperature at the boiler reads within the recommended range, yet some outlets exceed 45 degrees Celsius. The maintenance person stated they wondered if the thermometer is faulty as the hot water when tested using their hand did not feel as hot as 57 degrees Celsius. The maintenance person advised they plan to change the probe thermometer to a laser thermometer.</p> <p>An email received from the facility manager following the audit, stating "a laser thermometer has been purchased and got satisfactory readings". The FM also reported that the maintenance person has also arranged for further work on the boilers but the plumber does not think they are the problem and they will continue to monitor. A copy of recordings taken on the 20 February 2017 with the new thermometer showed although there was some consistency across the readings, several recordings were one degree above 45</p>	<p>resident outlets evidenced temperatures are consistently exceeding the required temperature.</p>	<p>temperatures at all resident outlets are consistently within the required temperature range.</p> <p>90 days</p>
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		degrees Celsius.		
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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.