# Clare House Care Limited - Clare House

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Clare House Care Limited

**Premises audited:** Clare House

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

**Dates of audit:** Start date: 15 February 2017 End date: 15 February 2017

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 59

# 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 |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Clare House provides rest home, dementia care and hospital level care for up to 69 residents. The service is operated by Greenvale Group Limited and managed by a general manager and two clinical managers. Residents and families spoke positively about the care provided.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service’s contract with the district health board. The audit process included review of policies and procedures, review of residents’ and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

This audit has resulted in four areas requiring action, in relation to new staff completing the orientation programme, staff training, staffing levels in the hospital, and restraint management. The three areas that were outstanding at the previous partial provisional audit have been fully addressed.

## 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. |

Open disclosure is described within policy and procedure documentation. Residents and family members were comfortable with the level of open disclosure occurring. Completed incident and accident forms showed that family members were being contacted and informed within the limits of individual resident’s preferences.

The needs of people with particular communication needs were being met and the organisation has access to interpreter services should they be needed.

A complaints process was in place and information about it was available in several formats. Residents and family members interviewed were aware of how to make a complaint. There was a complaint register that meets requirements, and this demonstrated that the recording of verbally expressed dissatisfaction has improved.

## Organisational management

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| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The Greenvale Group Limited is the governing body of Clare House Retirement Village and is responsible for the services provided at this facility. A business plan and a quality and risk management plan are documented and include the scope, direction, goals, values and mission statement of the organisation. Systems were in place for monitoring the services provided, including monthly reporting by the general manager and to the governing body.

The facility is managed by an experienced and suitably qualified general manager who is supported by two clinical managers and a clinical care manager.

A quality and risk management system was in place, which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control and restraint minimisation. Collection, collation and analysis of quality improvement data was occurring and was being reported to the monthly quality meetings. Quality improvement processes were evident.

Adverse events are documented on accident/incident forms and have been seen as opportunities for improvement. Corrective action plans were being developed, implemented, monitored and signed off. Actual and potential risks are identified and mitigated and the hazard register was up to date.

A suite of policies and procedures cover the necessary areas, are current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme is intended to ensure staff are competent to undertake their role. There was a systematic approach to identify, plan, facilitate and record ongoing training that includes regular individual performance review.

Staffing levels and skill mix are documented. A framework was in place that forms the basis of the development of the rosters. A roster of senior staff for responses out of hours is in place.

## 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. |

Residents receive timely, competent, and appropriate services in order to meet their assessed needs and desired outcome/goals. Each stage of service provision is undertaken by suitably qualified/experienced staff that are competent to perform the function. The interRAI assessment tool is fully implemented in the service. The processes for assessment, planning, provision, review, and exit are provided within timeframes that safely meet the needs of the resident and contractual requirements.

Care plans reviewed described the required support and/or intervention to achieve the desired outcomes. The provision of services and interventions was consistent with, and contributed to, meeting the residents' needs. Evaluation of care is consistently documented, at least six monthly.

The service provides an activities programme that reflects residents’ preferences. The activities are planned and provided to develop and maintain skills and interests that are meaningful to the residents.

A medication management system is in place that meets all legislative and guideline requirements. Staff responsible for medicine management are assessed as competent to perform the function for each stage they manage.

The menu has been recently reviewed by a dietitian as suitable for the older person living in long term care. Residents and family reported satisfaction with the meals and choices provided.

## Safe and appropriate environment

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

The sluice has been installed and associated equipment accessed since the partial provisional audit. Similarly, electrical equipment checks and the monitoring of hot water temperatures have been undertaken. Outdoor courtyards have been completed and are now safe and the building warrant of fitness was current. Furniture and equipment has been purchased and meets the needs of current residents. Additional furniture has been ordered for future residents.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Staff have been provided with two separate training sessions on restraint minimisation and safe practice during 2016. Those interviewed were aware of the differences between a restraint and an enabler. The restraint coordinator has been in her role for a number of years and is conversant with the standard. A restraint register was in place and forms in residents’ files showed that the use of restraint is being monitored.

## Infection prevention and control

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

Infection control surveillance was being undertaken according to the organisational infection control policies and procedures. Infections were being recorded and possible causes and contributing factors considered. Infection incidence data has been collated and analysed according to the rest home, dementia service, or hospital care areas, as well as collectively. Reports on infection surveillance and relevant recommendations have been made through the quality improvement system.

## 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 | 14 | 0 | 0 | 3 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 2 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | A fair complaints, concerns and compliments process is easily accessed. It is described within policies and procedures and complies with Right 10 of the Health and Disability Commissioner’s Code of Health and Disability Services Consumers’ Rights. All residents and relatives interviewed informed that they know how to make a complaint, or who to go to if they are dissatisfied. Copies of a brochure on how to make a complaint are at the front entrance and an information package provided on admission includes details about the complaints process. The complaints register lists complaints filed over 12 month timeframes from 1 April to 31 March of the following year. Each complaint notes the date, complainant, a brief outline of the issue, the date of action, what the action take was and what communication was made regarding the resolution. Any follow-up required is also documented. The service provider has improved the recording of complaints ensuring verbal reports of dissatisfaction are documented, reviewed and followed up for quality improvement purposes. Information obtained through the complaints process is being reported through the quality and risk management system.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | A policy and procedure on open disclosure describes the expectations of when it should be made and why. The need to provide residents and family members with information in an honest way is emphasised. Residents and family members are satisfied with the level of information they are being given and the timeframes it is provided within. One person had lodged a complaint about not having received communication in a timely manner and this has contributed to a raised organisation-wide awareness about open disclosure. A section of the incident and accident form requires the name(s) of those contacted and the time and date the contact was made following an adverse event. There is a policy on interpretation and translation services that includes details about how to access interpreter services. This notes the range of language formats that may be required including braille, sign language, te reo Maori or an interpreter for another language. There has not been any requirement to contact local interpreter services; however a whiteboard is being used to assist staff to communicate with one resident.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The purpose, values, scope, direction and goals of the organisation are described. While the focus of the organisation’s philosophy is around various aspects of residents’ total environment, the purpose is around providing a caring and safe community that enables residents to maximise their abilities and opportunities. The documents describe annual and longer term objectives and include associated operational plans. Monthly monitoring reports are provided to the owner and the board by the general manager. These include reports against the objectives, occupancy, details of financial performance, documentation reviews and quality and risk updates.The service is managed by a general manager who has a Bachelor in Health Science (Therapeutic Recreation). She is also village manager for the newly established retirement village and has oversight for one other local aged care facility. The personnel file of the general manager confirms she undertakes ongoing professional development opportunities that include management updates and has been in management roles under the Greenvale Group for six years. On the day of audit, the general manager was not available. Two clinical managers who are registered nurses (one in the rest home and one in the hospital) and a clinical care manager (dementia service) who is an enrolled nurse assisted with the audit. The management team, plus the personal assistant to the general manager, meet on a weekly basis. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a quality and risk system that is being consistently reviewed and updated. Staff informed they are required to sign that they have read the minutes of these meetings every month and were familiar with the contents. Topics covered are consistent with the terms of reference and include internal audits, a kitchen and a cleaning report, a health and safety report, a hazard register review, restraint, infection control, compliments and complaints, documents and policies and general business. In addition to the monthly quality and risk management team meetings, staff meetings, residents’ meetings and those for specialist areas, such as kitchen and cleaning, were evident. Although the staff meetings and specialist areas had dropped off in 2016, the quality and risk meetings had been maintained. The internal audit schedule is being adhered to and relevant corrective actions are developed and implemented as necessary. A continuous process of quality improvement is occurring; however, this was less rigorous than at the last audit and therefore the previous area of continuous improvement has not been upheld. A resident and family survey had been distributed but only two had been returned, therefore no analysis had been undertaken. Policies reviewed cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process (last undertaken June 2016), referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are updated on new policies or changes to policies and are required to sign they have read them. The clinical managers described the processes for the identification, monitoring and reporting of risks and for the implementation mitigation strategies. Consistent reviews of the components of the risk register and the 2016 risk plans have been occurring. A health and safety group contributes to the quality and risk meetings.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | Organisational policy and procedures describe essential notification reporting requirements. A document outlining what needs to be reported, when and to which authority, was on display in the general manager’s office. This notes the reporting of pressure injuries, health and safety concerns, any change of a manager, staff shortages, infection control, and the coroner for example. The clinical managers advised there have been no notifications of significant events made to authorities since the previous audit.Staff document adverse and near miss events on an incident and accident report form. A sample of completed incidents forms reviewed show these had been fully completed, incidents have been investigated, action plans developed and actions were followed-up in a timely manner. Adverse event data is collated, analysed and reported at quality and risk management meetings. Meeting minutes reviewed showed discussion in relation to trends, action plans and improvements made. One such example was the review in the number of residents’ falls from bed, which has resulted in an increased use of bedrails to ensure residents’ safety. An annual health and safety report included an overview of the outcome of investigations on adverse events. |
| 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.  | PA Moderate | Professional qualifications of registered and enrolled nurses, the podiatrist, the GPs and the dietitian are on file. The scope of practice for each staff person is noted in copies of professional registrations and in signed position descriptions in staff files. There is a full suite of human resource policies and procedures that cover human resources management processes. These are consistent with good employment practices and meet legislative requirements. A review of staff files and staff interviews confirmed that formal applications and pre-employment interviews are occurring, police checks and reference checks are being made and annual performance appraisals are occurring. Such processes confirmed that suitable staff have been employed to safely meet residents’ needs. There is a documented new staff orientation process that is comprehensive and appropriate for this facility. Not all staff files included evidence of having completed the orientation documentation and this is an area that requires attention. A range of completed competencies that are required for medicine management, moving and handling and hand hygiene for example were in staff files. Staff training records were viewed and these included attendance records for internally provided training sessions during 2016. There was limited evidence to confirm that care assistants are attending ongoing training, either external or internal, as required in the contract and nor was there evidence that the diversional therapist in the dementia service is completing the training requirements as detailed in the ARRC agreement.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | There is an organisational policy and procedure related to service provider levels and skill mixes to ensure safe service delivery. A registered nurse is on duty at all times and all registered and enrolled nurses, plus a list of nominated senior care assistants have a first aid certificate. There is a set of shift times and requirements that form the basis for the roster. This framework takes into account busier times and the type of service, with an example being the dementia service having additional staff late afternoon. All required shifts are being filled. An on-call roster has been re-introduced to support staff on duty out of usual business hours when clinical managers and the general manager are also on duty.Night shifts are adequately covered with a registered nurse and two care assistants in the hospital area. One care assistant in the dementia service, where all residents are mobile, is supported by two other care assistants, or a care assistant and an enrolled nurse in the rest home.During discussions with staff and the clinical nurse managers it became apparent that there are currently some challenges associated with staffing the hospital service. The need to remedy these challenges has been raised for corrective action to ensure the associated potential risks are mitigated.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | All aspects of medicine management are being undertaken according to medicine management policies and procedures, legislative requirements and the Ministry of Health guidelines for the management of medicine in aged care facilities. Most medicines are supplied by the pharmacy in a roller pack administration system. The medicines that are not pre-packed, such as liquid medicines, are individually supplied for each resident. The medicines and pre-packed medicine sheets are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the residents’ medicine prescription. The GP conducts medicine reconciliation on admission to the service and when the resident has any changes made by other specialists.Safe medicine administration was observed at the time of audit. All records were accurately completed.The medicines and medicine trolley are securely stored. The medicine fridge is monitored for temperature, with the sighted temperatures within medicine storage guidelines. The controlled drugs are stored in a locked safe in a secure room. All medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. The medicine charts recorded the regular, short course and pro re nata (PRN – as required) medicines for each resident. When medicines were discontinued, these were removed by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months. Medication competencies were sighted for all staff that assist with the medicine management; this included the RNs.The RN interviewed reported that there were no residents who self-administer medications, although processes are in place should this occur. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | A cook manages the kitchen and was interviewed during the audit. The current menu was reviewed by a dietitian in 2015 as suitable for the older person living in long term care, meeting a previous area requiring improvement. If there are changes to the menu these are recorded and referred to the dietitian at the next review. The cook keeps a record of any changes. All residents and whanau/family interviewed were very satisfied with the food and food services.Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. There is food available 24 hours for those who wish to snack at night.All aspects of food procurement, production, preparation, storage, delivery and disposal comply with current legislation and guidelines. Fridge and freezer recordings are undertaken daily and meet requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging. Evidence was seen of all kitchen staff having completed safe food handling certificates. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Services are being delivered according to information in residents’ individualised life style care plans. Short term care plans are being developed for short term problems such as skin tears and decreased mobility, pain and urinary infections. Progress notes reviewed demonstrated that care and support was consistent with the identified problems, personal goals and interventions, as described in the lifestyle care plans. Care staff informed they report any concerns about a resident, such as a change in their condition, both in the progress records and to RNs, and this was confirmed and observed during handover. Resident, family/whanau spoke highly of the level of care and support provided and consistently stated that all of their needs are being met. A range of equipment and resources was available, suited to the different levels of care provided and in accordance with the residents’ needs, for example raised chairs and monkey bars. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | On admission, a personal profile is completed for each resident. A detailed and individualised activity plan is developed and updated during review. A range of activities are planned for each month and copies of the monthly activity schedules showed that options are varied and appropriate for each service stream. The monthly plan is in each resident’s bedroom in a large print format. The activities person during interview described the planning and involvement of residents in preparing the programmes. Residents’ and family/whanau interviewed are happy with the activities available, and say they like the variety and confirmed there is no compulsion to attend, or participate if they are in the lounge during activity time. Residents who wish are assisted to undertake activities on a one to one basis and a record of this is retained.In the dementia wing a separate and individualised 24 hour activity plan is developed and reviewed for each resident. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Evaluation of both short and long term care plans is occurring in recommended timeframes with detailed outcomes/goals included. Both residents and family are consulted and are informed when changes are identified; this was confirmed during interviews and evidenced on the base of the care plan. Information is being included in progress notes and changes are being made to interventions when indicated. Care staff interviewed stated they are consulted prior to evaluations. |
| 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 | A documented process for the safe and appropriate storage and disposal of waste is being followed. Contractors remove rubbish skips as per the contract, recycling is occurring and hazardous substances removed safely. The sluice room equipment in the new hospital wing has been installed and waste disposal equipment is available. Staff have access to a range of personal protective equipment. Issues relating to the corrective action raised at the partial provisional audit have been fully addressed.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | All buildings, plant and equipment comply with legislation. Gas storage compliance documentation is displayed as is the certificate of pubic use that has an expiry date of 02 May 2017. A building warrant of fitness with an expiry date of 13 December 2017 has now been issued. Electrical checks have been completed and checks of hot water temperatures demonstrate these are at safe levels. The courtyards have been completed and these are safe and accessible. A resident and family member made comment on how beautiful these look. Equipment and furniture needed for current residents is all available; however dining tables and chairs and lazy boys for residents still to be admitted have not yet arrived. An order form was sighted and on the day of audit a phone call confirmed they had arrived in Invercargill and would be despatched to the facility by Friday. An area in a corner of the front of the dining room in the hospital wing has a hazard sign in situ stating there is an uneven surface as there is a slight difference in level between the floor and the door. This is precautionary only as its position and minimal risk is not currently posing a danger for staff, or residents. The area is on a list of new building touch ups to be completed. The corrective actions raised at the partial provisional audit have been addressed. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The type of surveillance for infection required and the frequency with which it is undertaken is clearly described within the infection prevention and control policies and procedures. One staff person from each of the three areas, rest home, dementia service and hospital care accept responsibility for collecting specimen samples when indicated and for completing an infection report form for any infection in their area. A copy of the report form is placed in the resident’s file and one in the quality improvement folder. The form includes a breakdown of the infection, possible causes, actions taken, conclusions and recommendations. This information is analysed and reported at the next monthly quality and risk management meeting. The information is graphed and is being compared with other months and data from the same timeframe in previous years. There was evidence of actions taken and recommendations made in response to the surveillance process.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | PA Moderate | Staff have access to policies and procedures on restraint minimisation and safe practice and in relation to managing challenging behaviours. Restraint minimisation is a component of the new staff orientation programme and staff training sessions on the topic were delivered in two separate months during 2016. Staff interviewed were familiar with the fact that enablers are voluntary, knew the principles of de-escalation and knew that any restraint use needs to be monitored. There was evidence of restraint monitoring in residents’ personal files and quality and risk management meetings minutes confirmed that the use of restraints is discussed during these. However, the overall system that underpins the management of restraint has not been upheld as required and this is an area for corrective action.  |

# 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.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.4New service providers receive an orientation/induction programme that covers the essential components of the service provided. | PA Low | A new staff induction/orientation programme is detailed in organisational policies and procedures. This includes a range of competencies that are required to be completed. Eight of twelve staff files did not include records of a completed orientation, or only contained one record on health and safety or restraint. The clinical managers explained that some of these gaps were because the staff person had been employed before such records were retained and some were because they had not yet been completed. An internal audit on all 68 staff files that was completed late 2016 was sighted and confirmed that eleven staff members, all of which had been employed between September 2016 and the audit had been identified as not having a completed orientation record on file. There were 37 care assistants on the staff list. Orientation records for those employed prior to these being filed were not checked for in this audit. A low risk rating has been attributed as documents provided showed that these staff have already been sent reminders and a deadline date given by which the documents are required to be presented to the general manager.  | An orientation programme that includes a range of competencies is provided; however, eleven staff have recently had to be reminded to return the associated paperwork, which is currently outstanding. | There is evidence that new employees complete an orientation/induction programme that covers the essential components of the services provided. 180 days |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | There is a system in place to identify, plan, facilitate and record ongoing education for service providers. An internal training schedule on suitable topics was implemented in 2016 and a comprehensive one is planned for 2017. However, attendance records for internal staff training in 2016 showed minimal attendance by care assistants. Not all names were checked but between staff training attendance records and seven care assistant staff files that were reviewed, there was evidence that at least eight care assistants had not completed any ongoing staff development within the preceding 12 month period. There was also limited evidence that once care assistants have completed their orientation they are undertaking or maintaining training requirements as listed in D17.6c (i – vii) of the ARRC Agreement. The activities coordinator responsible for the dementia service has supervision from the general manager who is suitably trained in recreational therapy. However, the activities coordinator does not have the qualifications or experience to meet contractual requirements as there was no evidence that she has skills in assessment, implementation and evaluation of diversional and motivational recreation (Clause E 4.5 c (ii) of the ARRC Agreement) and nor was there evidence in the staff file that this is planned.  | A staff education programme is in place; however, care assistants are not all completing ongoing education as required by the standard, or clause D17.6c (i – vii) of the ARRC Agreement. Also, the activities coordinator in the dementia service does not have the required qualifications or experience, nor is there evidence in the staff file that this is planned, as required in clause E 4.5 c (ii) of the ARRC Agreement. | Care assistants undertake ongoing education and the activities coordinator has the skills and experience, as required in the ARRC agreement.180 days |
| Criterion 1.2.8.1There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | Descriptions of heavy workloads and dependent residents requiring complex cares were repeatedly reported throughout the audit. Four weeks of roster prior to the audit were viewed and all but four short shifts had been filled. It is reportedly not uncommon when beds are not full for those shifts not to be allocated. There were also examples of staff having been consistently replaced in the event of staff sickness, or unplanned leave. However, staff reported that of late they have worked on what would be usual days off and they are working extended shifts more than previously to staff the hospital. Such examples were evident in the staff roster. There were reports of additional challenges since nursing students had left for the academic year. The clinical managers were unable to explain how they would adequately staff the hospital service with the upcoming roster should a staff member not be able to undertake their allocated shift, as there were no further casual staff to replace them with. They also confirmed that on the week of the audit they had refused a new admission on the grounds of not being confident to provide the person with the care needed due to no further staff being available. There are currently three staff undergoing orientation and two were being buddied on the day of audit, which means it will take time for these people to build their experience. The primary area of concern is within the hospital service where three care assistants and one registered nurse are responsible for the care and support of 21 dependent hospital level residents. It was also reported that of late the registered nurse mostly has to take a case load, which potentially compromises his/her usual work requirements. To date there have not been any designated shifts not worked and nor have there been any incidents reported due to a lack of competent staff. The hospital staffing levels also sit within the minimum levels of contractual requirements. This corrective action has been raised due to the likely risks associated with the current unpredictable staffing situation in the hospital area and because the staff levels and skill mix policy notes staff levels will reflect the complexity of care required.  | The staff numbers for the hospital services are not currently meeting safe levels with one registered nurse and three caregivers on morning shifts having to meet the needs of 21 dependent residents with complex needs. There is limited leeway to manage staff sickness and leave as there are few available casual staff, especially if new residents are admitted. | Ensure that service provider levels and skill mixes are at a safe level that enables the provision of safe service delivery to hospital residents. 90 days |
| Criterion 2.1.1.4The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Moderate | Residents who had been assessed as requiring restraint were having this implemented in a safe manner with relevant assessment and monitoring processes in place. However, there was no guarantee that safe practice could be maintained as there were two versions of the restraint management policy and procedure in the organisational policy and procedure manual. The policy refers to a restraint approval group; however staff interviewed were not aware there was such a group. The restraint coordinator was interviewed but did not know who some of the residents currently on the register were, as she had not been consulted about them. There was confusion among staff as to whether named residents were using bedrails as a restraint, or as an enabler, one entry was not dated and one entry was for a person no longer in the facility. An official role description for the restraint coordinator was not available and nor were there terms of reference for the restraint approval group referred to in the policy. | Due to conflicting restraint-related documentation and breakdowns in the implementation of the restraint management system, there is a potential for safe practices around restraint minimisation to be compromised.  | The restraint management system shall be implemented according to policies and procedures to ensure the needs of residents are met and that their independence and safety will be maintained. 90 days |

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

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

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End of the report.