

Social Service Council of the Diocese of Christchurch - Fitzgerald

Introduction

This report records the results of a Certification 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 Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

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| Legal entity: | Social Service Council of the Diocese of Christchurch |
| Premises audited: | Fitzgerald Retirement Complex |
| 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: 9 May 2017 End date: 10 May 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: | 76 |

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 |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |

| Indicator | Description | Definition |
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| | 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

Fitzgerald Retirement Complex is part of Anglican Living Aged Care organisation responsible to the Anglican Care Trust Board. Fitzgerald Retirement Complex provides care for up to 87 residents across rest home, hospital and dementia service levels. On the day of audit there were 76 residents.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board and Ministry of Health. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, physiotherapist, staff and a general practitioner.

The manager is an experienced registered nurse (RN) who reports to the director of Anglican Living. The manager and deputy manager are supported by three unit managers (registered nurses) and a quality coordinator.

This certification audit identified that there is an improvement required around updating of care plans and progress notes.

The service has been awarded three continued improvement ratings around: infection control surveillance; food services; and quality initiatives implemented in response to data collection.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Fitzgerald Retirement Complex practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is information available about the Nationwide Health and Disability Advocacy Service. Staff, residents and family verified the service is respectful of individual needs including cultural and spiritual beliefs. Cultural training is provided and individual values and beliefs are considered on admission and continuing through the care planning process. There is an open disclosure policy that staff understand. Family/friends are able to visit at any time and ongoing involvement with community activity is supported.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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The organisation has an annual business and quality plan in place with annual quality objectives. Quality information is reported to monthly quality/health and safety meetings and general staff meetings. The service is actively involved in ongoing quality projects to improve outcomes and service delivery for the residents. The service has comprehensive policies/procedures to provide rest home, hospital and dementia level of care. There is an orientation programme in place. There is a staffing policy that includes a documented rationale for determining staffing levels and skill mixes for safe service delivery. The staffing roster indicates there are adequate numbers of staff and registered nurses on duty to safely deliver care within a timely manner. A two-yearly rotating in-service education calendar is implemented.

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. | | Some standards applicable to this service partially attained and of low risk. |
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There is a comprehensive admission package available prior to or on entry to the service, including individual information for the dementia and psychogeriatric units. Residents' records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six-monthly. Residents' files include three-monthly reviews by the nurse practitioner or general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines complete education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three-monthly by the general practitioner.

There is a separate activities programme for each area, which is implemented that meets the needs of aged care residents. The programme includes community visitors and outings, entertainment and activities.

All food and baking is done on-site by a contracted external catering company. Residents' nutritional needs are identified and documented. Choices are available and are 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. |
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Services are provided in a clean and safe environment that is appropriate to the needs of the residents. The buildings holds a current warrant of fitness and reactive and preventative maintenance is completed.

Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are maintained. There is outdoor furniture, seating and shaded areas. The dementia unit has a safe indoor and outdoor environment with a patio, seating, shade and gardens.

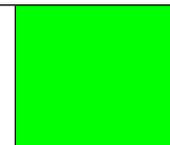
A number of rooms have full ensuite facilities. There are also numbers of communal toilets and showers close to bedrooms and lounges. All bedrooms are single (with the exception of two hospital rooms) and are spacious enough to manoeuvre transferring and mobility equipment, to deliver the assessed level of care.

Communal areas within the facility include lounges and dining areas in each unit. There is a family/whānau room located in each unit. All laundry and personal clothing is laundered off-site by a contracted laundry service. There are heat pumps in communal areas. All communal areas and bedrooms are heated and well ventilated and light.

There are emergency procedures in place at both buildings to guide staff should an emergency or civil defence event occur. There is at least one staff member on duty at all times with a first aid certificate.

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.

There is restraint minimisation and safe practice policies applicable to the service. There are currently two hospital residents using restraint and three hospital residents with enablers. Staff are trained in restraint minimisation and the management of challenging behaviour.

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.



All standards applicable to this service fully attained with some standards exceeded.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other aged care facilities. Staff receive ongoing training in infection control.

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) |
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| Standards | 1 | 48 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 3 | 97 | 0 | 1 | 0 | 0 | 0 |

| Attainment Rating | Unattained Negligible Risk (UA Negligible) | Unattained Low Risk (UA Low) | Unattained Moderate Risk (UA Moderate) | Unattained High Risk (UA High) | Unattained Critical Risk (UA Critical) |
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| 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 |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Fitzgerald Retirement Complex practices in accordance with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and posters of the Code are displayed throughout the rest home and the hospital/dementia buildings. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with staff (eight caregivers, four registered nurses (RN), three unit managers, five lifestyle facilitators, one property manager and one kitchen manager) reflected their understanding of the key principles of the Code.</p> |
| <p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed</p> | FA | <p>There are established informed consent policies/procedures and advanced directives. General consents obtained on admission were sighted in the nine residents' files reviewed. Advance directives if known were on the residents' files. Resuscitation plans for competent residents were appropriately signed. Copies of enduring power of attorney (EPOA) were in resident files for residents deemed incompetent to make decisions.</p> <p>An informed consent policy is implemented. Systems are in place to ensure residents and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. Residents and relatives interviewed confirmed they have been made aware of and fully understand informed consent processes and confirmed that appropriate information had been provided.</p> |

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| consent. | | Long-term resident's files reviewed had a signed admission agreement or were in the process of being signed. |
| Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Residents and families are provided with information about the Nationwide Health and Disability Advocacy Service. Advocacy pamphlets are displayed in the entrance to the rest home and hospital/dementia buildings. Caregivers interviewed are aware of the resident's right to advocacy services and how to access the information. Resident advocates are identified on admission. Interviews with residents and relatives confirmed that they are aware of their right to access advocacy. A Chaplain visits the facility 12 hours per week and residents interviewed also identified the Chaplain as an advocate. |
| Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community. | FA | The service maintains key linkages with other community and external groups including churches and schools. Residents are invited to community functions and events. Visiting arrangements are suitable to residents and family/whānau. Families and friends are able to visit at times that meet their needs. Discussion with staff, residents and relatives, determined that residents are supported and encouraged to remain involved in the community. |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedures have been implemented and residents and their family/whānau have been provided with information on admission. Complaint forms are available and staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained. Six complaints were received in 2016 and two complaints made in 2017 year to date. Follow-up letters, investigation and outcome was documented. Quality improvements have been implemented and any changes required were made as a result of the complaint. Residents and family members advised that they are aware of the complaints procedure and how to access forms. |
| Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is available at reception in both of the rest home and the hospital/dementia buildings. A manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the bi-monthly resident/family meetings. Nine residents (four rest home and five hospital) and three relatives (two hospital and one dementia care) interviewed, reported that the residents' rights are being upheld by the service and that they received sufficient information to be able to make informed choices on matters that affect them. |

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| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | FA | <p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified and church services are held. There is a policy on abuse and neglect and staff received training in July 2016.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | FA | <p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. Māori consultation is available through local Māori services. There is a cultural consultant and relationship specialist for Māori residents. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. Caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. At the time of the audit there were two residents in the service who identify as Māori. One Māori resident file reviewed confirmed that Māori cultural values and beliefs are being met and are addressed in the care plan.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | FA | <p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs. The service has a Chaplain appointed to the facility who is contracted to visit for 12 hours per week.</p> |

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| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregiver's role and responsibilities. Professional boundaries are reconfirmed through education/training sessions, staff meetings and performance management if there is infringement with the person concerned. Caregivers are trained to provide a supportive relationship based on sense of trust, security and self-esteem. Interviews with eight caregivers could describe how they build a supportive relationship with each resident.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>The director and management team are committed to providing services of a high standard, based on the service philosophy of care. This was observed during the day with the staff demonstrating a very caring attitude to the residents. Residents interviewed state they are very happy with the level of care provided. The service has implemented policies and procedures that are developed and reviewed by an external healthcare consultant. The policies and procedures meet legislative requirements. Caregivers interviewed state there are caregivers' guidelines in place to guide the delivery of care to residents. They receive a verbal handover from the RN and there is a daily handover sheet for every shift that details any significant events.</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>An open disclosure policy describes ways that information is provided to residents and families and the management team promotes this. The information pack contains a range of information regarding the scope of service provided to the resident and their family on entry and any items they have to pay for that is not covered by the agreement. A specific introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility. The information pack is available in large print and advised that this can be read to residents. Interpreter services are available as required. Three relatives interviewed, stated that they are informed when their family member's health status changes. This was confirmed on fourteen incident forms reviewed. Discussions with caregivers identified their knowledge around open disclosure. There are resident meetings held bi-monthly with the opportunity for feedback on the services.</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</p> | <p>FA</p> | <p>Fitzgerald Retirement Complex is part of Anglican Living Aged Care organisation responsible to the Anglican Care Trust Board. There is a director who has a Bachelor of Arts in Social Sciences and Post Graduate Diploma in Management. She has over 25 years' experience in aged care. The director reports monthly to the Anglican Living Committee. Fitzgerald Retirement Complex provides care for up to 87 residents across rest home, hospital and dementia service levels over 2 buildings (rest home and hospital/dementia). On the day of the audit, there were 76 residents (25 of 30 beds in rest home- including 1 resident on a long term chronic contract; 34 of 38 beds in hospital- including 1 resident on respite care; and 17 of 19 beds in dementia care).</p> |

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| <p>of consumers.</p> | | <p>The manager is an experienced RN who reports to the director of Anglican Living. The manager has been in the position since February 2013. A deputy manager who is also an experienced RN supports her. The manager and deputy manager are supported by three unit managers/RNs and a quality coordinator. The manager has maintained over eight hours annually of professional development activities related to managing a rest home.</p> <p>The organisation has a current annual strategic/business plan with clearly defined and measurable goals. Goals are regularly reviewed with the board and the management team. There is a strategic plan for the facility, which includes a vision, a mission statement and core values and a business plan 1 July 2016 – 30 June 2017.</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>During a temporary absence, the deputy manager/RN undertakes the role of manager. She has extensive aged care experience. The unit coordinator/RN (dementia) and the director of Anglican Living also support the deputy manager as required. Both have extensive experience in aged care nursing and management.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | <p>FA</p> | <p>Fitzgerald Retirement Complex has a quality coordinator who has been in the role for six months. Progress with the quality and risk management programme has been monitored through monthly quality/health and safety meetings and general staff meetings. Unit managers attend these meetings and feedback to their own areas. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff confirmed their involvement in the quality programme. Resident meetings are held bi-monthly. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2016 has been completed and 2017 is being implemented. Areas of non-compliance identified at audits have been actioned for improvement. The service has a quality improvement focus.</p> <p>There are implemented risk management and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/procedures to support service delivery. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. Policy has been amended to meet interRAI requirements. Residents and relatives are surveyed annually to gather feedback on the service provided (with positive results) and the outcomes are communicated to residents, staff and families. Falls prevention strategies include: residents experiencing</p> |

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| | | <p>frequent falls had an increase in monitoring to pre-empt impromptu activity; ensuring fluids are at hand; call bells are within reach; falls prevention education for staff through toolbox talks; and fall prevention pamphlets/poster presentation throughout the service.</p> <p>A health and safety representative (one property manager) was interviewed about the health and safety programme. Five health and safety representatives have completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. The data is tabled at staff and management meetings. A review of the hazard register indicates that there is resolution of issues identified.</p> |
| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | FA | <p>Incident and accident data has been collected and analysed. A sample of fourteen resident related incident reports for April 2017 were reviewed. All incident reports and corresponding resident files reviewed, evidence that appropriate clinical care has been provided following an incident and all have been signed off. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Monthly and annual review of incidents is completed. Discussions with the director and manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | FA | <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Ten staff files were reviewed (one manager, two unit managers, one quality coordinator, one RN, four caregivers and one diversional therapist) and included all appropriate documentation. The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. Agency staff receives an orientation that includes the physical layout, emergency protocols and contact details in an emergency.</p> <p>A two-yearly rotating in-service education calendar is implemented and exceeds eight hours annually and has covered appropriate topics. The RNs attend external training including seminars and education sessions with the local DHB. A competency programme is in place with evidence of annual medication competencies for the RNs and senior caregivers. Core competencies are also completed for all staff relating to fire and emergency plans. Fourteen of eighteen caregivers who work in the dementia unit have completed the required dementia</p> |

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| | | standards. The four that have not completed are new staff who are currently completing the dementia standards training and have worked in the unit for less than twelve months. |
| <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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Care staff reported that staffing levels and the skill mix was appropriate and safe. Families/whānau and residents interviewed stated that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that the unit managers or the manager will be on call at all times. The manager and the unit managers work full-time.</p> <p>In the hospital, there are two RNs on duty on the morning and afternoon shifts and one RN on the night shift. The RNs are supported by six caregivers (various times) on duty in the morning shift, five caregivers (various times) in the afternoon shift and two caregivers at night.</p> <p>In the rest home, there is a RN who covers the morning shift Monday-Friday. A senior caregiver is on duty on afternoon and night duty and also on morning shifts at the weekends. The RN/senior caregiver are supported by four caregivers (various times) on duty in the morning shift, two caregivers (various times) in the afternoon shift and one caregiver at night. The management team provide on call cover after hours and the hospital RN can be contacted at any time.</p> <p>The dementia unit has a RN who covers the morning shift Monday- Friday. A senior caregiver is on duty on afternoon and night duty and also on morning shifts at the weekends. The RN/senior caregiver is supported by three caregivers (various times) on duty in the morning shift, three caregivers (various times) in the afternoon shift and one caregiver at night. The RN from the hospital is available at any time and after hours on call cover is provided by the management team. Two relatives interviewed advised that there is sufficient staff on duty in the dementia unit to provide the care and support required.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>The resident files are appropriate to the service type. Residents' files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Information containing sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public.</p> |

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| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | <p>FA</p> | <p>The admission handbook outlines access, assessment and the entry screening processes. The service operates twenty-four hours a day, seven days a week. Comprehensive information about the service is made available to referrers, potential residents and their families. Resident agreements contain all detail required under the Aged Residential Care Agreement, including specific information on the dementia unit. Family members and residents stated that they have received the information pack and have received sufficient information prior to and on entry to the service. Family members reported that the manager and unit managers are available to answer any questions regarding the admission process.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | <p>FA</p> | <p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The service uses the CDHB "Yellow Envelope" for acute admissions to public hospital. A transfer form accompanies residents to receiving facilities and communication with family is made. One file reviewed was of a hospital resident that had been transferred to hospital acutely. All appropriate documentation and communication was completed. Transfer to the hospital and back to the facility post-discharge, was well documented in progress notes, including medication reconciliation and update of changes to residents needs communicated to family/EPOA.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | <p>FA</p> | <p>The service has introduced an electronic medication management system. The medication management policies and procedures comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Resident's medicines are stored securely in the medication room/cupboards. Medication administration practice complies with the medication management policy for the medication round sighted. There was evidence of three-monthly reviews by the GP. Registered nurses and senior caregivers administer medicines. All staff who administer medications complete annual medication competency and medication management education. Eighteen individual resident's electronic medication charts were sighted (seven rest home, four dementia and seven hospital). Resident medication charts are identified with photographs and allergies recorded. All prescribed 'as required' medications documented the indication for use. All medications were evidenced to be administered as prescribed. The facility uses a pre-packed medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Temperature monitoring of the medication fridges was evidenced to be completed daily. There were no residents self-administering medication on the day of audit. Since the transition onto an electronic medication management system, standing orders are no longer in use.</p> |

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| <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 service contracts an external catering company to provide the food service at Fitzgerald Retirement Complex. The residents' individual food, fluids and nutritional needs are met. Residents are provided with a balanced diet, which meets their cultural and nutritional requirements. The meals are cooked on-site. Food is sent to the individual unit servery's in hot boxes. Food temperatures are recorded when food is placed in bain maries and on exit from kitchen. Fridge temperatures are recorded for the fridge in each servery.</p> <p>A kitchen cleaning schedule was in place and implemented. The chiller, fridge and freezer temperatures were monitored. The kitchen was observed to be clean and well organised and all aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.</p> <p>There is a summer and winter menu that has been reviewed by a registered dietitian who also provides dietetic input around the provision of special menus and diets where required. A dietary assessment is completed on all residents at the time they are admitted. Residents with weight loss are reviewed and dietary modifications made as required. Residents with special dietary needs have these needs identified. Resource information on these diets is available in the kitchen. Feedback on satisfaction with meals is obtained from residents. Corrective actions are undertaken if required.</p> <p>Special equipment is available and on observing mealtimes, it was noted there were sufficient staff to assist residents.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | <p>FA</p> | <p>There is policy in place regarding the process for declining entry. Consumers are declined entry when there are no beds available. If a potential admission was declined entry, the consumer and where appropriate their family/whānau of choice, is informed of the reason for the decline and advised to contact Older Persons Health.</p> |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p> | <p>FA</p> | <p>The interRAI initial assessments and reviews are evident in printed format in all resident files. Resident files reviewed identify that risk assessments have been completed on admission and reviewed six-monthly as part of the evaluation. Additional assessments for management of behaviour, pain, wound care, nutrition, depression score, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care</p> |

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| gathered and recorded in a timely manner. | | <p>plans.</p> <p>Currently nine of ten registered nurses have completed interRAI training. One registered nurse is currently attending an interRAI training course. The interRAI assessment is completed to identify current resident needs within required timeframes. Staff interviewed are familiar with current resident needs.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>The long-term care plans are resident-focused and personalised. The care plans describe the resident goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process. There is documented evidence of resident and/or family input ensuring a resident focused approach to care. Residents confirmed on interview they are involved in the care planning and review process. There is evidence of allied health care professionals involved in the care of the resident. Long-term care plans sampled have been reviewed and updated. Short-term care plans are developed following a change in health. Interventions documented are sufficiently detailed to address the desired outcome/goal. Integration of records and monitoring documents are well managed.</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> | PA Low | <p>Continence products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed and this could be described. Dressing supplies are available and all treatment rooms are stocked for use. Wound management policies and procedures are in place. The service is currently managing fourteen wounds including two stage II pressure related injuries. All wounds had wound management plans in place. The pressure related wounds have a care plan written which include pressure prevention measures and the GP had sighted both wounds. Chronic wounds have been linked to the long-term care plans.</p> <p>There is external specialist input into residents. The nurse practitioner for Mental Health of Older Persons, visits regularly.</p> <p>Care staff interviewed could describe strategies for the provision of a low stimulus environment and management of behavioural issues using a person centred approach to care.</p> <p>Long-term care plans reviewed did not consistently document interventions or updates to interventions when a resident's health changes. Follow-up assessment by a registered nurse of concerns documented in progress notes was not consistently evidenced.</p> <p>Monitoring occurs for: vital signs; turning charts; wounds; restraint; continence; weight; BSLs; food and fluid intake; and pain monitoring. Registered nurses review the monitoring charts and report identified concerns to the GP or nurse practitioner for Mental Health of Older Persons.</p> <p>Short-term care plans document appropriate interventions to manage short term changes in health.</p> |

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| <p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>There are five lifestyle facilitators at Fitzgerald Retirement Complex; one is a qualified diversional therapist. Two staff provide activities in the dementia unit seven days a week. One staff member facilitates the rest home activities programme and two staff provide activities to hospital residents. Activities staff have either the NZQA dementia qualifications or are working towards achievement of these. The five lifestyle facilitators interviewed reported that they modify the programme related to the response and interests received from residents. Resident's capability and cognitive abilities were considered in planning of the activities programme. The activities programme covers physical, social, recreational, spiritual and emotional needs of the residents.</p> <p>The activity programme is planned monthly. Activities planned for the day are displayed on noticeboards around the rest home, dementia and hospital areas. A diversional therapy plan is developed for each individual resident, based on assessed needs of the functional activity assessment completed on admission. Diversional therapy plans are reviewed six-monthly in files sampled. Activity progress notes are maintained. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. Community groups are invited to participate in the programme. The service has links with the local kindergarten and boys school. The service has a van that is used for resident outings. A volunteer driver drives the van and a lifestyle facilitator accompanies residents on van outings. Resident meetings provide a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>Care plans of permanent residents reviewed have been evaluated at least six-monthly in files sampled. There is evidence that interRAI assessments are completed when there is change in the resident's needs or medical condition. The care plan evaluations are resident focused and describe residents progress to meeting identified goals. When health status changes acutely, short-term care plans were utilised and any changes to the long-term care plans had been dated and signed in files sampled.</p> <p>All initial care plans are evaluated by the RN within three weeks of admission.</p> |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or</p> | <p>FA</p> | <p>The service facilitates access to other services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents' and or their family/EPOA are involved as appropriate when referral to another service occurs.</p> |

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| disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | | |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | FA | <p>Management of waste and hazardous substances is covered during orientation of new staff. Chemicals are stored safely in a locked cupboard. Safety data sheets and product wall charts are available. All chemicals were labelled correctly. Approved sharps containers are available and meet the hazardous substances regulations for containers. Gloves, aprons and goggles are available for staff at the point of use. Infection control policies state specific tasks and duties for which protective equipment is to be worn. Staff were observed to be wearing appropriate personal protective clothing when carrying out their duties. There is a chemical spills kit available. Staff have attended chemical safety training.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | FA | <p>The building holds a current warrant of fitness which expires on 01 April 2018. The buildings are single storey. The service is provided over two buildings on the same site with the rest home in one building and the hospital and dementia unit in the other building. The service has single rooms in the rest home and dementia unit. The two double rooms currently have single occupancy in the hospital unit with the remainder of the room's single occupancy. The corridors and rails promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are maintained. There is outdoor furniture, seating and shaded areas. The dementia unit has a safe indoor and outdoor environment with a patio, seating, shade and gardens.</p> <p>Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. There is a maintenance programme in place. Hot water temperatures are monitored monthly. For any temperatures above the target of 45 degrees Celsius, corrective actions have been implemented and the issue resolved. All medical equipment sighted was calibrated in November 2016.</p> <p>The caregivers and RNs interviewed stated that they have all the equipment referred to in care plans necessary to provide care.</p> |
| Standard 1.4.3: Toilet, | FA | Fifteen resident rooms in the rest home and fourteen in the hospital, have full ensuite facilities. There are no |

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| <p>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>ensuite rooms in the dementia unit. There are adequate numbers of communal toilets and showers close to bedrooms. Toilets are located close to dining rooms and lounges for residents' use. A visitor's toilet is available in each area. Toilets have privacy locks. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Residents interviewed report their privacy is maintained at all times.</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> | FA | <p>All bedrooms are single (with the exception of two hospital rooms) and are spacious enough to manoeuvre transferring and mobility equipment, to deliver the assessed level of care. The two double rooms in the hospital had single occupancy on the day of audit. The double rooms in the hospital have privacy curtains and two call bell points. Residents are encouraged to personalise their bedrooms as desired.</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> | FA | <p>Communal areas within the facility include lounges and dining areas in each unit. There is a family/whānau room located in each unit. The communal areas are easily accessible for residents. There are quiet areas available for the residents.</p> <p>Residents (as able) were observed to be moving freely with the use of mobility aids. Furniture was well arranged to facilitate this. All dining rooms and lounges can accommodate specialised lounge chairs. Seating and space is arranged to allow both individual and group activities to occur in each area.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> | FA | <p>All laundry and personal clothing is laundered off-site by a contracted laundry service. There is a separate storage area for dirty laundry. Laundry is picked up and delivered daily. There is a linen storage area in the hospital where clean laundry is sorted and folded. Cleaner's trolleys are stored in locked areas when not in use.</p> |

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| <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>There were adequate linen supplies sighted in the facility linen-store cupboards. Internal audits monitor the effectiveness of laundry and cleaning processes. The chemical provider audits the effectiveness of chemicals for laundry and cleaning services.</p> <p>Residents and relatives interviewed are happy with the laundry and cleaning services provided.</p> |
| <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> | <p>FA</p> | <p>There are emergency procedures in place at both buildings to guide staff should an emergency or civil defence event occur. A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six-monthly fire evacuation practice documentation was sighted. A fire evacuation drill was last completed on 12 April 2017. Fire training, emergency evacuation and security situations are part of orientation of new staff and ongoing training. Emergency equipment is available. Civil defence wheelie bins situated in each area (hospital, rest home and dementia) are available (sighted). The staff confirmed that they have civil defence equipment including alternative cooking methods (gas supplied to the kitchen and barbeques). Gas heaters are available if required.</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> | <p>FA</p> | <p>The facility has overhead heating and individual wall heaters which can be adjusted in each resident's room. There are heat pumps in communal areas. All communal areas and bedrooms are well ventilated and light. Residents and family interviewed, stated the temperature of the facility is 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</p> | <p>FA</p> | <p>The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practices and reporting. The rest home unit manager is the infection control coordinator and is responsible for infection control across the facility. An external aged care consultant is responsible for the development of the infection control programme and its review. The infection control programme is well established at the facility. The Infection Control Committee consists of a cross-section of staff and there is external input as required from general practitioners and public health.</p> |

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| appropriate to the size and scope of the service. | | |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>There are adequate resources to implement the infection control programme. The infection control coordinator has maintained best practice by attending external infection control seminars. The infection control team is representative of the facility. External expertise is available from the Southern Community Microbiologist. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection</p> | FA | <p>The infection coordinator is responsible for coordinating/providing education and training to staff. Orientation package includes specific training around hand hygiene and standard precautions. Infection control training is regularly held, including (but not limited to): outbreak management (April 2016) and infection prevention & control and hand hygiene in November 2016.</p> |

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| control to all service providers, support staff, and consumers. | | |
| <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> | CI | <p>The surveillance policy describes the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility. Individual infection report forms are completed for all infections. This is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Infection control data is collated monthly and reported at the various facility meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality management programme. Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. A review of outbreak management has occurred following a recent outbreak in 2016, which evidenced an improved outcome when the facility had another outbreak in August 2016.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p> | FA | <p>There is restraint minimisation and safe practice policies applicable to the service. Guidelines of the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register. There are currently two hospital residents using restraint and three hospital residents with enablers. Staff are trained in restraint minimisation and the management of challenging behaviour.</p> |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and</p> | FA | <p>The restraint coordinator is the hospital unit manager who has considerable experience in aged care and has been employed at the facility for two years. Assessment and approval process for a restraint intervention includes the RN, resident/or representative and general practitioner (GP).</p> |

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| others. | | |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | FA | The service completes assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau. The restraint coordinator, resident and/or their representative and a GP are involved in the assessment and consent process. Consent for the use of restraint is completed with family/whānau involvement and a specific consent for enabler/restraint form is used to document approval. These were sighted in the two restraint files and two enabler files reviewed. |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | FA | The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes completed. There is an assessment form/process that is completed for all restraints. Two restraint files reviewed had completed assessment forms and the care plan reflects risk. Monitoring forms that included regular two-hourly monitoring (or more frequent) were present in the files reviewed. Two files reviewed had a consent form detailing the reason for restraint and the restraint to be used. A monthly evaluation of restraint is completed that reviews the restraint used. The service has a restraint and enablers register for the facility that is updated each month. |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | FA | The service has documented evaluation of restraint every month. In the two restraint files reviewed, evaluations had been completed with the resident, family/whānau, restraint coordinator and GP. Restraint practices are reviewed on a formal basis annually by the restraint approval group and monthly by the facility restraint coordinator at the quality/health and safety meetings. |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | FA | The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator with family and GP. Any adverse outcomes are included in the restraint coordinators monthly report and are reported at the monthly quality/health and safety meetings. |

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) |
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| <p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p> | PA Low | <p>Multidisciplinary meetings occur six-monthly. Rest home and dementia files reviewed identified that the care plans include current interventions to guide care. However, this was not evidenced in two of four hospital files reviewed. RN follow up of concerns documented in progress notes was evidenced to be completed in rest home and hospital files reviewed.</p> | <p>(a) Two hospital care plans reviewed had not been updated to include management of weight loss and specific de-escalation and distraction techniques that could be used to manage behavioural issues identified; and</p> <p>(b) Progress notes for two dementia residents did not evidence follow up by a registered nurse regarding documented changes to skin (possible pressure injury to sacrum) and resident complaint of a painful foot.</p> <p>NB: These were all rectified at the</p> | <p>(a) Ensure care plans are updated when there is a change to resident needs; and</p> <p>(b) Ensure registered nurse follow up of caregiver concerns written in progress notes is</p> |

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

| Criterion with desired outcome | Attainment Rating | Audit Evidence | Audit Finding |
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| Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | CI | There is a comprehensive quality and risk management process in place. Monitoring in each area is completed monthly, quarterly, six-monthly or annually as designated by the internal auditing programme schedule. Audit summaries and action plans are completed as required, depending on the result of the audit. Key issues are reported at the quality committee and an action plan is identified. These were addressed in meeting minutes sighted. Benchmarking reports are generated throughout the year to review performance over a 12-month period. | As a result of quality data collected through the dashboard system; due to the high number of resident falls in 2016, Fitzgerald Retirement Complex implemented a falls prevention programme in October 2016 which focused on identifying strategies for the reduction of resident falls. Strategies included (but not limited to): residents experiencing frequent falls had an increase in monitoring to pre-empt impromptu activity; ensuring fluids are at hand; call bells are within reach; falls prevention education for staff through toolbox talks; and fall prevention pamphlets/poster presentation throughout the service. Documentation reviewed identified that strategies were regularly evaluated. The total of resident falls for the period from 1 November 2016 to 30 April 2017 was 178 compared to 231 in the period from 1 April 2016 to 31 October 2016. The outcome achieved was that the service reduced the number of falls by over 20% during the last six-month period. |

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| | | <p>Quality improvement plans are utilised at Fitzgerald Retirement Complex and document actions that have improved outcomes or efficiencies in the facility. The service continues to collect data to support the implementation of corrective action plans. Responsibilities for corrective actions are identified. There is also a number of ongoing quality improvements identified through meeting minutes and as a result of analysis of quality data collected. Fitzgerald Retirement Complex is proactive in developing and implementing quality initiatives. All meetings include feedback on quality data where opportunities for improvement are identified.</p> | |
| <p>Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p> | <p>CI</p> | <p>All meals are overseen by the kitchen manager of the external catering company who is on-site Monday-Friday. All meals are cooked on-site. The menu is reviewed by a dietitian. The last dietitian review of the menu was completed in April 2017 with no corrective actions or recommendations made. The kitchen manager reported being kept well informed of residents changing dietary needs and this was confirmed by residents and family members interviewed. Residents interviewed were very</p> | <p>The service commenced a quality improvement in May 2016 with the goal of improving the dining experience for hospital residents. Improvements implemented included: a review of the seating plan (on consultation with residents); new table settings; fresh flowers on the tables; care staff on duty being allocated specific tables to serve (providing a waitress service); simple garnishing of meals; and education provided to those staff serving and assisting at mealtimes. Those residents who require assistance with feeding are included in the dining experience and are brought to the dining room in special mobility chairs which are able to be placed around the dining table. Resident meetings reviewed evidence that the kitchen manager attends these meetings and is provided with feedback regarding the meal service and dining experience. A review in October 2016 and survey completed in May 2017 evidences improved resident/relative satisfaction with the dining experience. The residents report a calm, organised and relaxed atmosphere in the dining room at meal times. Residents and families report that meal times are now a real "social experience, the waitress service is wonderful and the improved seating plan allows for better</p> |

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| | | complimentary about the food service and praised the staff for their attention to detail, both in food preparation and presentation of the food. | interaction". The service has achieved its goal to create a positive dining experience which has become part of the Anglican "Living Together" culture. |
| Criterion 3.5.7 Results of surveillance, conclusions, and specific recommendations to assist in achieving infection reduction and prevention outcomes are acted upon, evaluated, and reported to relevant personnel and management in a timely manner. | CI | The service has an Infection Control Committee that meets monthly, as a subset of the quality management meeting. Surveillance data is reviewed at this meeting and where required, corrective action plans are developed. The Infection Control Committee undertook a post incident review following an outbreak in 2014 and 2016 and recommended and implemented a number of improvements to the way an outbreak is managed. | The service had an infectious outbreak (Norovirus) in June 2016. A total of 23 residents and 24 staff members were symptomatic in two units. The appropriate notifications were made and the infectious outbreak protocol implemented. A post outbreak review was completed with staff and containment and isolation strategies were developed to manage any further outbreaks. Staff were provided with additional training on hand-washing, infectious outbreak management and standard precautions. The service had another norovirus outbreak in August 2016. The improvements made as part of the review of the previous outbreak were implemented. The outbreak was contained in the hospital wing. |

End of the report.