# The Kawerau Social Services Trust Board

## 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:** The Kawerau Social Services Trust Board

**Premises audited:** Mountain View Home & Hospital

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

**Dates of audit:** Start date: 28 August 2017 End date: 28 August 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:** 47

# 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

Mountain View Home and Hospital provides rest home and hospital level care services for up to 50 residents. On the day of audit there were 19 residents receiving rest home level care and 28 residents receiving hospital level care. The owner manages the facility. All the residents and the family members interviewed, spoke very positively about the staff, personalised care and the standard of services received.

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

There were no shortfalls identified at the last audit. This audit identified that improvements are required in relation to medicine competency assessment processes.

## 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. |

Staff communicate with residents and family members following any incident in a manner that reflects open and honest communication.

Staff, residents and family members are aware of the complaints process. Complaints are being investigated and addressed and a complaints register is being maintained.

## 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. |

The organisation’s vision, values and goals are documented in the business plan. The experienced manager regularly reports to the board of trustees. A charge nurse is responsible for oversight of clinical care.

The quality programme includes complaints management, incident reporting and policy and procedure review. There is a risk management plan and hazards are being identified and reviewed. Internal audits and surveys are regularly conducted. The manager and charge nurse are aware of the events that require external reporting. Regular resident and staff meetings occur. Current policies and procedures are available to guide staff.

Staff recruitment includes the applicant completing a job application. Reference and police checks are conducted. Annual performance appraisals have been completed for applicable staff. An orientation programme is in place for new employees and records of this are maintained. Staff have access to relevant ongoing education.

The staffing and skill mix requirements are documented and aligns with the provider’s contract with Bay of Plenty District Health Board. At least one registered nurse with a current first aid certificate is rostered on every duty.

## 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. |

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff, a podiatrist, community physiotherapist, pharmacist and a designated general practitioner. On call arrangements for support from senior staff are in place. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents` records reviewed demonstrate that needs, goals and outcomes are identified and reviewed regularly. Residents and family members interviewed reported being kept well informed and involved in care planning and evaluation.

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

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using a manual system. Medications are administered by registered nurses and senior care staff.

The food service meets the nutritional needs of the residents with special needs being catered for. A food safety plan and policies guide food service delivery, supported by the kitchen team with food safety qualifications. The kitchen is well designed, managed, organised and meets food safety standards. Residents and families verified satisfaction with the meals.

## 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 building has a current building warrant of fitness. Some renovation and refurbishment has occurred in parts of the facility. No changes have been necessary to the fire evacuation plan.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint minimisation and safe practice policies and procedures reflect current good practice and meet legislative and Health and Disability Service Standard requirements. Enablers are described as voluntary. Staff education related to restraint minimisation occurs during orientation and is included in the annual education plan to maintain restraint use. At the time of audit three restraints are being used and no enablers.

## 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. |

Surveillance for infections is undertaken monthly. Results of surveillance are analysed to assist in promoting infection reduction. The surveillance results are appropriately reported to staff and management in a timely manner.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **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 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 1 | 0 | 0 | 0 |

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| **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).

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| **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 | Mountain View Home and Hospital implements organisational policies and procedures to ensure complaints processes reflect a fair complaints system that complies with the Code. During interview, residents, family/whānau and staff reported their understanding of the complaints process.  A complaints register is maintained and associated records verified complaints are investigated and responded to in a timely manner. Very few complaints are received. There have been no complaints received from the District Health Board, Ministry of Health or Health and Disability Commissioner since the last audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Open disclosure is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The three family members and residents interviewed expressed satisfaction with staff and communication processes, and the timeliness of communication. This included reporting of changes in health status, medications, and following incidents / accidents. Communications with family members were documented in the residents’ clinical records.  All current residents speak English. Staff could detail how interpreters would be accessed if required. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Mountain View Home and Hospital has a documented vision, purpose, philosophy, values and goals detailed in the 2016/2017 business plan. The manager and members of the management team monitors the progress in achieving goals via resident / family feedback and monitoring of the results of quality and risk activities. The manager formally reports to the board of trustees, who normally meets monthly.  The manager has worked at Mountain View Home and Hospital for many years. She is an experienced registered nurse, with a current annual practising certificate. The manager’s role and responsibilities are detailed in the position job description. The manager participates in relevant ongoing education as required to meet the provider’s contract with Bay of Plenty District Health Board (BOPDHB).  On the day of the audit there were 47 occupied beds inclusive of 28 hospital level and 19 rest home level residents.  Since the last audit there has been a review and restructuring of the clinical leadership team. Previously there was a charge nurse for the rest home and a charge nurse for the hospital services. There is now one charge nurse (appointed to this role in 2016) with overall responsibility for all clinical services, and a registered nurse team leader for the rest home and hospital services. The local general practice provides medical services. This has historically been shared amongst the general practitioners (GP). Recently one general practitioner with an interest in care of the elderly has commenced providing the majority of regular GP services for residents.  Since the last audit there has been some renovation and refurbishment of parts of the facility. This included changing the facility entrance area and administration office areas, and relocating the treatment room and where some of the medicines are stored.  The service has a contract with BOPDHB DHB for the provision of aged related long-term support, and residential and respite services. There are also several private paying residents. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Mountain View Home and Hospital has a quality and risk management system which is understood and implemented by service providers. This includes internal audits, satisfaction surveys, incident and accident reporting, health and safety reporting, hazard management, infection control data collection and management, restraint minimisation, and compliments / complaints management. Regular internal audits are conducted and demonstrated a high level of compliance with organisation policy.  If an issue or deficit is found, a corrective action is put in place to address the situation. Corrective actions are developed and implemented and monitored for effectiveness.  Quality information is shared with all staff via shift handover as well as via the regular staff meetings. Staff interviewed verify they are kept well informed of relevant quality and risk information. The quality meeting is where all components of the quality and risk programme are reviewed, analysed and responded to. There have been three meetings in 2017 to date. Designated registered nurses are responsible for monitoring specific activities / resident outcomes including infection prevention and control, restraint minimisation / use of enablers, wounds and pressure injuries, and residents’ nutritional status. Outcomes are analysed monthly, trended over time and reported to the quality meeting. A review is undertaken of all residents who are transferred to the DHB hospital for any reason.  Bi-monthly meetings are held with residents to obtain resident feedback on services, food, and activities. The minutes of the 2017 meetings were sighted for residents, along with the results of the annual resident satisfaction survey that was conducted late 2016. The feedback from residents in the satisfaction survey was very positive.  Policies and procedures were readily available for staff. Policies are routinely reviewed one or two yearly (as identified on each document) or sooner where required. Three paper copies of policies are available for staff. Where amendments are made to policy, the administrator is responsible for document control processes.  Staff, resident and family/whānau interviewed expressed a high level of satisfaction about the services provided. This was verified during review of the results of the annual staff satisfaction survey  Actual and potential risks are identified in the risk management plan, along with mitigation strategies. These were last reviewed in May 2017. Staff confirmed that they understood and implemented documented hazard identification processes. The hazard register sighted was current and detailed hazard mitigation strategies. The health and safety committee meets three monthly. |
| 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 | Policy and procedure details the required process for reporting incidents and accidents including near miss events. Staff are provided with education on their responsibilities for reporting and managing accidents and incidents during orientation, and the ongoing education programme.  Applicable events are being reported in a timely manner and also disclosed to the resident and/or designated next of kin. This was verified by residents and a family member interviewed. A review of reported events including falls, challenging behaviour, a staff injury, and a skin tear, demonstrated that incident reports are completed, investigated and responded to in a timely manner. Changes were made to the resident’s care plan where applicable or a short-term care plan developed where necessary. Staff communicated incidents and events to oncoming staff via the shift handover. Completed incident forms are filed in the residents’ files once all interventions have been undertaken and the event / incident information included in the monthly quality and risk monitoring processes.  The manager and charge nurse can detail the type of events that require essential notifications. Two notifications have occurred to the Ministry of Health since the last audit. |
| 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. | FA | Copies of the annual practising certificates (APCs) were sighted for the general practitioner (GP), the other GPs who provide services in the GP’s absence, the two pharmacists, and all the registered nurses (RNs) and enrolled nurses (EN’s).  Recruitment processes includes completing an application form, conducting interviews and reference checks. Police vetting is occurring for new staff. Staff have a job description on file. The job description, employment contract, confidentiality agreement includes a statement advising staff of privacy / confidentiality requirements. Annual performance appraisals have occurred in the applicable staff files sampled.  New employees are required to complete an orientation programme relevant to their role. A checklist is utilised to ensure all relevant topics are included. New employees are buddied with senior staff for a number of shifts until the new employee is able to safely work on their own. A new staff member interviewed felt supported and verified the training was thorough.  A staff education programme is in place with in-service education provided regularly. The topics are scheduled over a two-year period and align with the facilities contract with BOPDHB. Education provided in 2017 includes (but is not limited to); fire safety, health and safety, civil emergency events, falls prevention, manual handling, medicine management, pain management, infection prevention and control palliative care, challenging behaviours, the Code of Rights, restraint minimisation and cultural safety. Staff can also attend relevant external education. Records of education are maintained and copies of education certificates are present in the staff files reviewed. In-service invitations / reminders are distributed. This details the names of staff who are requested to attend where applicable, or alternatively if all staff are invited. Mandatory education is detailed. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Policy identifies staffing levels and skill mix are maintained to meet residents’ needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty to provide safe appropriate care.  There are staff specified on the rostered to work in the rest home and hospital wings on each shift. There is a minimum of two caregivers rostered on duty overnight. There are at least eight caregivers rostered for part or all of the morning shift. This includes the caregivers who have special duties. There is at least one registered nurse on duty all shifts. A registered nurse is also rostered in the rest home at least eight morning shifts a fortnight, in addition to the RN in the hospital wing. Two enrolled nurses also work rostered shifts in addition to the RNs. All RNs including the charge nurse and the manager have a current first aid certificate.  Rosters sighted showed that staff were replaced for sickness or unplanned leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents’ needs.  Resident and family/whānau members interviewed stated all their, or their family member’s needs have been met in a timely manner.  The service has dedicated cleaning and laundry staff seven days a week. There is a cook rostered on morning and afternoon duty as well as kitchen assistants. Maintenance services are provided on site weekdays. This is shared between three personnel.  The manager and charge nurse work Monday to Friday and are available after hours if required for urgent issues. An administrator works Monday to Friday.  The manager has advised there have been some challenges with implementing the pay equity settlement for caregivers. The manager advises she has been in regular contact with the BOPDHB portfolio manager about this and the associated concerns. Some changes have been made to rostering, and the service is currently reviewing the frequency of staff meetings. |
| 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. | PA Low | The medication policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. The training records and individual staff files were reviewed. Not all staff who administer medicines had completed medicine competencies annually. There were three of nine registered nurses who had not yet completed Niki T34 syringe driver training.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription when delivered from the pharmacy and when administered to the individual residents. All medications sighted were within current use by dates. Clinical pharmacist input is provided on a regular basis.  Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries are maintained.  The records of temperatures for the medication fridges reviewed were within the recommended range.  Good prescribing practices noted include the prescriber`s signature and data recorded on the commencement and discontinuation for medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly general practitioner review is consistently recorded on the medicine chart.  There were no residents’ self-administering medications at the time of audit. Appropriate processes are in place to ensure this would be managed in a safe manner.  Medication errors are reported by staff to one of the two team leaders or to the charge nurse and these are recorded on an incident form as per policy. The resident and/or designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process was verified.  Standing orders are used, were current and complied with guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by a qualified chef and kitchen staff and is in line with recognised nutritional guidelines for older people. The menu follows the summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (March 2017).  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration was issued 31 March 2017. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food safety and handling training.  A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident`s nutritional needs, is available.  Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes reviewed. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident`s individualised needs was evident in all areas of service provision. The general practitioner interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care in individualised and of a high standard. Care staff confirmed care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents` needs. |
| Standard 1.3.7: Planned Activities  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. | FA | The activities programme is provided by and activities coordinator who is a member of the New Zealand Diversional Therapy Society and has been in this role since 1995. Two assistants are available to assist with the programme and volunteers are welcome to assist.  A social/activities assessment and history is undertaken on admission to ascertain resident`s needs, interests and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident`s activity needs are evaluated six monthly as part of the formal six monthly care plan review.  The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. The seven day a week activities programme is displayed weekly in all service areas for family and residents. Activities reflect resident`s goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples include exercise, games, indoor golf, indoor bowls, van outings or mystery trips, craft activities, hair dresser visits and singalong/music sessions. The activities programme is discussed at the minuted residents` meetings and indicated resident`s input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme fun, stimulating, interesting and verified that varied activities are provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported by the care staff to the registered nurse or team leader.  Formal care plan evaluations, occur every six months in conjunction with the six monthly interRAI reassessment or when a resident’s needs change. Evaluation are documented by the registered nurse. Where progress is different from expected, the service responds by initiating changes the plan of care. Examples of short term care plans were consistently reviewed and progress evaluated as clinically indicated and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans are evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility has a current building warrant of fitness with an expiry of 12 November 2017. No changes have occurred to the facility with the exception of some renovation / refurbishment activities involving the main entrance and office areas and relocation of the treatment room and some medicine storage. The fire evacuation plan has not required amendment. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | All staff are required to take responsibility for surveillance activities by reporting any signs and symptoms of infection to the registered nurse(s) on duty. Monitoring is discussed in meetings to reduce and minimise risk and ensure residents’ safety. The RN team leader for the rest home is designated as the infection prevention and control nurse. He completes a monthly surveillance report. The service monitors respiratory tract infections, wounds, skin, urinary tract infections, eye infections, gastroenteritis and other infections for rest home and hospital level residents’ separately. The monthly analysis of the infections includes comparison with the previous month, types of infections and organism cultured (where applicable), trends and actions taken to reduce infections. This information is fed back and discussed with registered nurses, at the quality meetings, and where appropriate, to residents/family members. Caregivers are informed of confirmed or suspected infections during shift handover. The RNs liaise with the GP in the event an infection is suspected. This was verified during interview with the GP. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The team leader restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation`s policies, procedures and practice and her role and responsibilities. A job description for this role was reviewed.  On the day of the audit, three residents were using restraints and no enablers were in use. A similar process is utilised for the use of restraints and enablers. This provides for a robust process which ensures the on-going safety and wellbeing of the resident.  Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes and files reviewed of those residents who have approved restraints and from interview with staff. |

# 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 1.3.12.3  Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Low | There is a medicine competency assessment process that staff administering medicines are required to complete. Staff able to administer medicines includes the registered nurses, enrolled nurses and caregivers who can undertake special duties. The designated staff are required to complete competencies for the administration of oral medicines during orientation or prior to medicine administration and then annually thereafter. The registered nurses also complete a competency for the use of syringe drivers every two years with Hospice nursing staff. Training records were reviewed. | Records are not currently available to demonstrate that all nurses have completed the Niki T34 syringe driver competency within the last two years. Three registered nurses of a total of nine are yet to complete this requirement. Three registered nurses are overdue annual oral medicine competency assessments. | Ensure all staff administering medication have completed annual competencies and that the registered nurses have all completed the required competency for managing the Niki T34 syringe driver.  180 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.