

Glenhays Limited - Northanjer

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Glenhays Limited
Premises audited:	Northanjer
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 8 November 2017 End date: 8 November 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:	15

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

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

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

General overview of the audit

Northanjer is a small 15 bed rest home in Oamaru, the largest town in North Otago in the South Island. A ‘sister’ facility called Southanjer sits on the outskirts of Oamaru and provides dementia care services. Both facilities are owned by a company called Glenhays Ltd., which purchased them in May 2017. A couple who are the majority shareholders manage these facilities.

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

Evidence obtained throughout the audit confirmed that the service has continued to function at a high level and that residents and family members remain satisfied with the services provided.

There were no areas identified as requiring improvement at the previous audit; therefore, no criteria other than for a routine surveillance required specific follow-up. Two corrective actions, both of which are related to the medication system, were raised during this surveillance event.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.



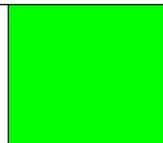
Standards applicable to this service fully attained.

Effective open communication processes between staff, residents and families were verified for routine information, as well as following circumstances, such as an adverse event. There is access to formal interpreting services if required.

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

An operations manager/manager and a business manager live on site, although the latter is out of town three days a week. The operations manager, alongside an on-site registered nurse, are responsible for the services provided at this facility. A documented business plan and a quality and risk management plan include the scope, goals, and mission statement of the organisation. Systems are in place for monitoring the services provided.

The manager is a registered physiotherapist who is quickly gaining experience in the management of this facility and developing suitable skills and knowledge. Quality and risk is being managed via an annual calendar of internal audits, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings. Adverse events are

documented and followed up as opportunities for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register was up to date.

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

Human resources policies and procedures are based on current good practice and guide the systems for recruitment, appointment and management of staff. A comprehensive orientation and staff training programme ensures staff maintain the required competencies for their role. Systems are in place to provide ongoing staff education and record achievements. Staff have access to external training opportunities.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. An on-call system ensures the manager is readily available and staff always has access to registered nurse advice and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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A registered nurse lives on site and the manager or registered nurse input is available 24 hours over seven days a week. Shift handovers guide continuity of care.

Care plans are individualised and based on a comprehensive range of clinical information. Short term care plans and wound plans are developed to manage specific, or new problems that might arise. All residents' files that were reviewed demonstrated that

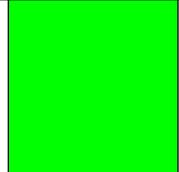
needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families reported during interviews that they are well informed, involved in decision-making and that the care provided is of a high standard.

A planned activity programme is overseen by two activity coordinators, one of whom is training to become a diversional therapist. The programme provides residents with a variety of individual and group activities and enables them to maintain links with the community. A facility van is available for outings.

Policies and procedures on medicine management based on current good practice are available. Medicines are stored safely. The manager and registered nurse have undertaken a recent review of medicine management. Medications are administered by caregivers, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs and personal preferences catered for. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with the meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There have not been any modifications to the building since the last audit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of the audit. Staff receive training on restraint and enabler use and on de-escalation techniques at orientation and thereafter every two years. Those interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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All infections are recorded on a reporting form. Aged care specific infection surveillance is undertaken, with the graphing and analysis of infection data being completed monthly. The registered nurse/infection control coordinator subsequently provides reports that are presented to staff and quality meetings. Resulting follow-up actions are recommended, and relevant education is provided when indicated.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	1	0	0
Criteria	0	37	0	0	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>A complaints policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). This information is provided to new residents by the manager or the registered nurse during the admission process. Information about making a complaint, brochures on accessing the advocacy service plus copies of complaints forms are near the front entrance of the facility.</p> <p>The complaints register was reviewed. This showed that five complaints, some of which had been verbally expressed dissatisfactions, have been investigated since the facility manager took over in May 2017. Notes, records of the actions taken, and copies of the related correspondence were on file and demonstrated required timeframes had been met and all had been resolved. Action plans reviewed showed improvements have been made where possible. One resident had been assisted to access the advocacy service for an issue she was experiencing elsewhere.</p> <p>The facility manager is responsible for complaints management and follow up. Staff confirmed during interview that they fully understood the complaint process and know what the advocacy service is.</p>
<p>Standard 1.1.9: Communication Service providers</p>	<p>FA</p>	<p>Staff who were interviewed understood the principles of open disclosure. An open disclosure policy document meets the requirements of the Code. Family communication recording forms are being completed and copies were sighted in residents' files. Residents stated that staff keep them well informed about what is going on and help them to</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>better understand information, such as after a doctor's visit. Both family members interviewed said they are consulted about anything that is happening and reported they are always told about any adverse events.</p> <p>An interpreter policy is in the policy manual. Interpreter services are able to be accessed via the local hospital and wider District Health Board should they be required. Longer term caregivers stated that over the years only one person had not had English as their first language and this had been well managed.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Southanjer and its sister rest home Northanjer on the main highway through the township of Oamaru are managed by an operations manager and her partner who is the business manager. They are the majority shareholders in a company called Glenhays Ltd. The company purchased the facilities in May 2017 and although the manager's partner lives in another town for some of the week, he commutes to assist with maintenance and provides advice and support as appropriate. There is a team of business advisers and accountants supporting the managers. A business plan developed in April 2017 sits alongside a quality and risk plan in outlining the purpose, values, scope, direction and goals of the service. The documents describe annual and longer term objectives and the associated operational plans. These focus on qualities such as dignity, respect, friendliness, treating people as individuals and providing a homelike environment.</p> <p>The manager is a qualified physiotherapist who has a current practising certificate, specialist knowledge in neurological rehabilitation and extensive experience in rehabilitation of the older adult. She has been in the role since 22 May 2017. The previous manager assisted her with a planned orientation over a three month period and continues to be available to answer questions. Since commencing her role at Northanjer, the manager has completed interRAI training for managers, has attended the Aged Care Association Conference, completed assessor training through a training facility and has enrolled in an auditing in healthcare training course.</p> <p>During interview the manager confirmed she has developed some strong networks, continues to be committed to the task she and her partner have taken on and is fully aware of her limitations. The manager was able to describe regulatory and reporting requirements. She is assisted by a registered nurse and it was observed that they both work as a team to manage this facility.</p> <p>The service holds a contract with the local District Health Board to provide rest home level care. Respite care may be provided but is dependent on bed availability.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has</p>	<p>FA</p>	<p>Northanjer's manager has access to the quality consultant who was used by the previous manager. The quality consultant has provided a quality and risk plan that has proven suitable for small aged care rest home facilities, including Northanjer. The plan is based on a 'Strengths, Weaknesses, Opportunities and Threats' (SWOT) analysis of various operational aspects of the service. Staff were familiar with the system and spoke of aspects of it, such as incident reporting, complaints and internal audits, during interviews. Systems implemented for managing quality and</p>

<p>an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>risk are identical at both Northanjer and Southanjer homes. The quality committee meetings are combined; however, the data is kept separate. Information is shared with the manager and the registered nurse and representative caregivers from both homes, in order to enhance the learnings.</p> <p>Policy and procedure documents, including a policy on document control, were current with the last review being October 2017. These have been supplied by, and are being maintained by, the quality consultant. There was no evidence of obsolete documents and all were in the required format.</p> <p>Implementation of the quality and risk management plan was evident in the monthly staff meeting minutes, the three monthly residents' meeting minutes and the minutes of a general committee meeting. All meeting minutes demonstrated staff involvement and included details on internal audits, complaints, hazards, risks, infections and a range of reports on health and safety and resident related care issues. Reports included analyses of quality related data and internal audit and survey results. Corrective actions have been identified and are followed through to improvements. Examples included one on a higher than preferred number of medication errors, and another on the need for a higher level of cleaning of the conservatory. Both had specific action plans that were implemented. Observable and significant improvements were evident at re-audit.</p> <p>The risk management plan has clearly identified risks. Each identified risk has a list of monitoring processes against them that are a component of one part or another of the quality and risk management system. A person(s) responsible for the ongoing monitoring is identified. The manager and staff were positive about the systems in place and reference to their effectiveness was in a recently published newsletter that covers both Northanjer and Southanjer.</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</p>	<p>FA</p>	<p>During interview, the manager was able to quote a range of circumstances that would require reporting to a higher authority. Examples included reporting pressure injuries, death of a resident, significant injuries, and the routine quarterly contract reports, for example. A copy of a document on essential notification reporting requirements has been strategically positioned in the manager's office/nurses' station to facilitate ease of reporting such events. Since the manager took over the facility in May 2017, one notification of a death and a pressure injury sustained at the end of the person's life has been reported.</p> <p>Policy and procedures on the management of incidents/accidents and adverse events were sighted. Incident forms are completed by the staff involved in the adverse event. Staff confirmed that completing these is automatic for them when things go wrong. All of the incident forms that were reviewed during the audit had been followed up by the registered nurse and/or the manager. The section on open disclosure demonstrated who had been contacted and when. Each incident was individually followed up and a summary feedback report developed. Monthly incident/accident forms have been completed and graphs developed. Incidents had been collectively analysed over time, which is the process that enabled the manager and registered nurse to identify the increase in medication errors.</p>

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<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>A suite of human resources related policies, procedures and forms that cover recruitment, employment and training of staff were reviewed. Annual practising certificates for health professionals who provide services to the residents including GPs, the registered nurse, pharmacists, physiotherapist and podiatrist, have been verified and reviewed for currency. Staff files were reviewed and demonstrated the policies and procedures are being implemented with evidence of formal applications being made, police and referee checks, staff interviews and an induction process. Northanjer has some long standing staff members and the entry records were not necessarily complete in their file. All had a current and renewed employment contract and signed position description. The orientation programme is comprehensive and where records were available, they demonstrated the topics had been checked off and signed. Staff performance appraisals were mostly due in August and September. Although a three monthly review had been undertaken with new staff, the manager informed she had purposely not undertaken performance appraisals as she wanted to settle into the role and enable staff to get to know her and vice versa prior to proceeding with them.</p> <p>Relevant competencies including medication, first aid and emergency management were up to date for all staff. A 2017 and a 2018 calendar for staff in-service training is in place and include a variety of on-line and formal presentations from both internal and external people. The topics are consistent with contractual requirements. Records of staff training are being maintained in staff files and in an education folder in which overviews and attendance records for in-service sessions are filed. Caregivers are being encouraged and assisted to undertake externally facilitated certificate courses to upskill and broaden their knowledge.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>A staffing rationale and skill mix policy and procedure were sighted. The manager informed that most of the roster is the same as before she took on the role, although she did note that she has increased staff hours on Sundays to address a reported shortfall. In addition, she has employed two casual staff, one of which was a former employee, as it had been difficult to cover gaps in the roster when staff went on leave, or were sick. Staff confirmed during interview that they appreciated these changes. They also noted that on the rare occasion when extra assistance is needed, such as when a person deteriorated, either a casual staff person is brought on as an extra, or the registered nurse or manager step in to assist. Records sighted confirmed that all staff except the activities coordinator have a current medication competency and all staff have a current first aid certificate. A person with extra experience is designated as senior on all shifts.</p> <p>A registered nurse lives on site and the manager is only a phone call away. Both are on call at different times, which ensures there is always cover in the event of an emergency. They also act as back up for each other at Northanjer and the sister facility of Southanjer down the road. Use of the on-call person is documented on an incident form.</p> <p>The roster involves two people being on duty on morning shifts, one of whom works 7.30am to 2pm and the other 8am to 5.30pm. An afternoon shift person staff person works 4pm (or 4.30pm) to 11pm, which means there are always two people on at meal times. One person works the night shift of 11pm to 7.30am. Staff reported that overall</p>

		staffing levels are manageable and safe and that they feel well supported by the registered nurse and the manager.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>The medication management policy is current and identifies all aspects of medicine management in line with relevant legislation and the Medicines Care Guide for Residential Aged Care.</p> <p>Medicines are stored safely in a locked medicine trolley and locked cupboards in the nurses' station, which is kept locked when unoccupied. A numeric key pad combination lock is in situ. Records of temperatures for the medicine fridge showed they were within the recommended range.</p> <p>The staff person observed administering medications followed accepted good practice processes. All staff at Northanjer, except for a new person, have a medicine administration competency. Records of these were checked and all were current.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by the registered nurse against the prescription and a signing form is available for this process. All medications sighted were within current use by dates.</p> <p>Use of controlled drugs is minimal. Controlled drugs are stored securely in accordance with requirements and are checked by two staff prior to administration.</p> <p>Medication errors are reported and followed up through the incident reporting process. As noted in 1.2.3, when an increase in medicine errors was identified, the process was followed. Additional staff education was provided on medicine management safety and all staff were required to redo their competency.</p> <p>The required three monthly GP reviews were consistently being recorded on the residents' medicine records. Verbal orders are not used and nor are any standing orders in place. Medicine records are faxed to the GP if interim medicines are required between formal reviews. The GPs are signing these within the required timeframe.</p> <p>A corrective action has been raised in relation to the need for improved compliance with policy and legislative requirements around the checking of controlled drugs, reconciliation processes, prescribing practices and the signing of topical medicines. Practices around the self-administration of medicines also require review and a second corrective action has been raised to address these.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's</p>	FA	<p>Meals are cooked on site by a selected group of caregivers who have undertaken both cook and caregiver roles for a number of years. Two of the staff involved described how infection prevention and control issues are being managed for them to be able to safely undertake the dual roles. The menu, which has been approved by a registered dietitian in February 2017, has a five week rotational cycle with seasonal summer and winter variations. The summer change is due to occur in the third week of November.</p>

<p>individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>The person responsible for the admission process of new residents completes a nutritional profile with them, a copy of which remains in the person's file and one in the kitchen. Personal food preferences and individual dietary requirements were on display in the kitchen and a staff person who prepares the meals described how these are accommodated in the daily meal plan.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. For example, temperatures of the fridge, freezers and hot food are being consistently monitored and recorded. Foods are dated, kept sealed and stored according to recommended practices. Kitchen assistants have completed relevant food handling training.</p> <p>Evidence of resident satisfaction with meals was verified during resident interviews and in resident meeting minutes. A food survey was undertaken in August and changes were subsequently made through corrective action processes. This had made a difference for one resident in particular. Residents are encouraged to join others in the dining room for their meals; however, staff will take meals to residents' rooms if they prefer. None of the current residents require assistance with their meals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents stated during interview that the staff provided them with the care and support they need. They all noted that their personal preferences were also respected. Documentation, observations and interviews verified the provision of care provided to the residents was consistent with their needs, goals and the plan of care. During interview, the GP informed that medical input is sought in a timely manner, that medical orders are followed, and that Northanjer is serving a real need in the community. Caregivers confirmed that they use care plans to guide the care and support they provide to residents as well as information provided at staff handovers and observations they make of the residents on the day.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the</p>	<p>FA</p>	<p>A pre-planned monthly activity programme enables residents to participate in a diverse range of activities. One activities coordinator who was interviewed on the day of audit described how she plans most of the monthly programmes, contributes to their implementation and writes up some of the activity review records in residents' files. Options of activities for residents emerge from resident feedback, individual preferences, resource availability and the Golden Carer's website.</p> <p>A second activities coordinator, who is a caregiver and currently undertaking training as a diversional therapist, was not interviewed but was reported as the person who develops residents' personal profiles, assists residents with their goals and also maintains activities records. Examples of this documentation were sighted during the review of residents' files. The monthly activity programme demonstrated one on one, group, internal and external options are provided. There is a facility van and on the day of audit a number of residents went to lunch and a concert in the town with residents from other facilities. Residents expressed appreciation for the variety of things they get to do</p>

service.		<p>and the way the activities coordinators assist them to pursue their own personal interests.</p> <p>The manager described, and provided evidence of progress to date, on a project intended to ensure residents have a sense of purpose. This has so far involved a one on one survey and the institution of specific individualised and personalised activity options of each resident's choice. Although the project is in its infancy there are plans in place for it to be evaluated.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurse is responsible for the interRAI reassessments and the review and evaluation of service delivery plans. These are being consistently completed in a timely manner. InterRAI reassessments are completed first and any required changes are subsequently made to the service delivery plan. Examples of such changes were sighted.</p> <p>Evaluation reports are comprehensive and records sighted demonstrated that each identified issue in the care and support plan is reviewed and a summary documented. Residents informed that they believe that any changes in their health and wellbeing are addressed promptly and on two occasions during the audit, the registered nurse followed up on requests for help with problems and care related assistance from residents.</p> <p>The activity plans are being followed up by an activity coordinator and reviews were being completed.</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>Northanjer has a current building warrant of fitness dated 17 August 2017 that has an expiry date of 24 July 2018. There have been no structural modifications to this facility since the last audit. The facility is maintaining required compliance checks of the building and equipment including electrical checks, monitoring of hot water and room temperatures and the general maintenance programme.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p>	FA	<p>Infection surveillance is occurring as described within the infection prevention and control policies and procedures, which were current. Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results.</p> <p>Any infection that is identified, is documented on an infection report form. The registered nurse, who is also the infection control coordinator, follows up on all infections and involves the GP as required. Data from infection report forms is collated each month and a brief analysis of the data is documented on the monthly infection analysis forms.</p>

<p>and methods that have been specified in the infection control programme.</p>		<p>Bar graphs are developed and accompany these forms.</p> <p>Reports of the analysis of infection related data are presented to the staff meetings and at the quality meetings. Although no trends have been identified to date, the registered nurse informed that when a resident does get an infection, she takes the opportunity to remind staff at handovers of preventive techniques such as the importance of hand hygiene, supporting residents with good cough etiquette and not to go to work when unwell.</p> <p>The registered nurse and manager chose to restart the data gathering process for infection surveillance when they commenced in May 2017. Consequently, an annual infection surveillance report was not available.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures and associated forms for restraint minimisation and safe practice meet the requirements of the restraint minimisation and safe practice standards. These documents provide guidance on the safe use of both restraints and enablers, should they be required. Approved restraints if required are lap belts or bed rails. The manager/restraint coordinator was aware of her specific related role and responsibilities should restraint use be required. During interview, both the manager and the registered nurse described their understanding of the restraint related documents.</p> <p>There were no residents using either a restraint, or an enabler, on the day of audit. The restraint register did not include any recent use of a restraint with the last being for a person for one day in 2016 prior to her being transferred to hospital.</p> <p>Staff spoke of ongoing education on restraint use and were familiar with the differences between a restraint and an enabler and confirmed neither are currently being used at Northanjer.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and</p>	<p>PA</p> <p>Moderate</p>	<p>The manager and registered nurse informed they had completed their own internal reviews of the medicine management system. Implementation of the medicines management system was further reviewed during the audit, as was a review of residents' medicine records. Medication reviews, storage and disposal of medicines meet requirements. There were aspects of the prescribing that were not consistent with expected best practice including the need for pro re nata (PRN) medicines to have a reason for their use alongside the prescription and that a medicine required twice a week is not recorded as 'PRN'. Medicine administration recording sheets did not include topical medicines with active pharmaceutical ingredients and the system for the return of medicines following social leave requires review. Sign off of weekly controlled drug checks and medicine reconciliation processes are not consistent.</p>	<p>A review of medicine management systems has occurred; however not all aspects of implementation of these systems are being undertaken according to required legislation and guidelines:</p> <ul style="list-style-type: none"> - Not all pro re nata (PRN) medicines have a purpose documented against them. - Social leave 	<p>Medicine management practices are reviewed to ensure they are implemented according to the service provider's policies and procedures, relevant legislative requirements and the medicine care guidelines for aged residential</p>

guidelines.			<p>medicines were found loose in plastic sleeves in the medicines folder with no supporting documentation on the medicine record or in progress notes.</p> <ul style="list-style-type: none"> - The signing of medicine reconciliation processes and of the weekly controlled drugs checks are not all up to date. - Topical medicines with active pharmaceutical ingredients are not being consistently signed for when administered. - There is a lack of clarity about the administration of a topical medicine that is prescribed as being PRN but self-administered by the resident twice weekly but not signed for. 	<p>care.</p> <p>90 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-</p>	<p>PA</p> <p>Moderate</p>	<p>A policy and procedure on self-administration of medications is in place. There are three people currently self-medicating one or more of their medicines, although on the day of audit only two had a current</p>	<p>Three residents are self-medicating one or more of their</p>	<p>Requirements of the organisational</p>

<p>administration of medicines by consumers where appropriate.</p>		<p>competency to demonstrate they were capable of doing so. All three are being managed differently with one person having a transportable plastic lock box, one person having loose medicines in a drawer and another having a bottle of pills in the dresser drawer. Staff informed that all three people were passionate about doing this and were responsible, there had not been any incidents related to the current systems and no-one else entered their rooms. Risk assessments were not evident and records of medicine administration for the medicines that these people are self-administering were not being completed.</p>	<p>medicines. Only two of the three had a self-medication competency on file. None of these were stored in a locked cabinet or drawer, one person had loose tablets in their drawer and checks of when and if they had been taken were not occurring.</p>	<p>self-administration policy and procedure are met, including that individual competency and risk assessments are undertaken to ensure safe processes are in place.</p> <p>60 days</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, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.