

Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa

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 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:

Legal entity:	Golden Age Rest Home Limited
Premises audited:	Albarosa Rest Home Camellia Court Rest Home Golden Age Retirement Village
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 2 November 2017 End date: 3 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:	126

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
	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

Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa provides rest home and dementia level care for up to 133 residents. At the time of the audit there were 126 residents in total.

Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa is part of the Golden Healthcare Group (GHG), which operates seven facilities in Christchurch. The GHG organisation has a corporate services manager and an operations manager (human resource & compliance), who report to the director of all the GHG facilities. The organisation employs a quality assurance manager and a group clinical manager who both work across all facilities and provide support to the facility managers and registered nurses. There is a facility manager in each of the Camellia Court, Golden Age and Albarosa facilities.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Service Standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

Four of four shortfalls identified at the previous audit have been addressed. These were around staff designation in clinical records, timeliness of assessments, care plan evaluations and medication charting.

This audit has identified further improvements required around care plan interventions, wound assessments, food safety and emergency/security procedure.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Communication with residents and families is appropriately managed and documented. The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth by the Health and Disability Commissioner.

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.
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Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa is implementing a quality and risk management system. The quality programme is reviewed at each quality improvement and risk management meeting. The organisation also holds bi-monthly quality and risk senior team meetings where the organisational goals and plans are reviewed. Quality data is collated for accident/incidents, infection control, internal audits, concerns, complaints and surveys. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an annual education and training schedule in place for 2017. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Residents are assessed prior to entry to the service and a baseline assessment is completed on admission. Registered nurses are responsible for care plan development with input from residents and family. Family interviewed confirmed that the care plans are consistent with meeting residents' needs and were happy with the care. Planned activities are appropriate to the resident's assessed needs and abilities and family interviewed advised satisfaction with the activities programme. The facility uses an internet based electronic medication system. Medications are stored securely. Staff receive training in medication management and have current competencies. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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A current building warrant of fitness is displayed in each facility.

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 service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. There are currently no residents requiring restraint and no enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control surveillance programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The group clinical manager is the infection control coordinator with support from the registered nurses. There is a suite of infection control policies and guidelines that meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated. Benchmarking of data occurs.

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	3	1	0	0
Criteria	0	39	0	3	1	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>	FA	<p>A complaints policy and procedure has been implemented and residents and their family/whānau are provided with information on admission. The residents and families interviewed from each of the facilities were aware of the complaints process and to whom they should direct complaints. Complaints forms are in a visible location at the entrance to the facility. The facility managers maintain a record of all complaints, both verbal and written, by using a complaint's register. There had been one complaint made in 2017 year-to-date for Golden Age Rest Home, two complaints received in 2017 year-to-date for Albarosa and six complaints made in 2017 year-to-date for Camelia Court. The complaints reviewed demonstrated investigation, follow-up and responses to the complainant. All the complaints reviewed had been resolved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Eight residents (rest home) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. There is an incident/accident reporting policy and reporting forms that guide staff around their responsibility to notify family of any resident accident/incident that occurs. Eighteen incident/accident forms were reviewed for October 2017 all identified that next of kin were contacted. Nine relatives (seven rest home and two dementia care) stated that they are informed when their family members health status</p>

		changes. Regular resident and family meetings provide a forum for residents to discuss issues or concerns. An interpreter policy and contact details of interpreters are available. The information pack is available in large print and this can be read to residents.
<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>	FA	<p>Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa provides rest home and dementia level care for up to 133 residents. At the time of the audit there were 126 residents in total. There were 53 of 54 in the rest home facility (Golden Age Rest Home), 33 of 39 in Camelia Court dementia facility and 40 of 40 (two units of 20 beds) in the Albarosa dementia facility. There was one rest home respite resident. All residents are under the age related residential care (ARRC) agreement.</p> <p>Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa is part of the Golden Healthcare Group (GHG), which operates seven facilities in Christchurch. The GHG organisation has a corporate services manager and an operations manager (human resource & compliance), who report to the director of all GHG facilities. The organisation employs a quality assurance manager and a group clinical manager. They both work across all facilities and provide support to the facility managers and registered nurses (RN). There is a facility manager in each of the Camellia Court, Golden Age and Albarosa facilities and all are experienced in aged care and management. The Golden Age rest home facility manager has been in the position for 12 years, Camellia Court facility manager has been in the role for one year and Albarosa facility manager for seven years.</p> <p>There is an overall GHG group strategic plan for 2017–2022 that includes the organisations purpose, scope, goals and structure. Each individual facility has a one-year plan that includes objectives for 2017. The GHG quality and risk management programme for 2017 includes a quality programme for Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa with clearly defined goals and objectives. Additional quality improvement projects have been developed and are being implemented. Across GHG, benchmarking groups are established for facilities with similar service levels. Benchmarking of key clinical quality and incident data is conducted.</p> <p>The facility managers have all completed at least eight hours of professional development related to managing a rest home/dementia care service.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	FA	<p>Golden Age Rest Home Limited - Camellia, Golden Age, Albarosa is implementing a quality and risk management system. The quality programme is reviewed at</p>

<p>Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>each quality improvement and risk management meeting. The organisation also holds bi-monthly quality and risk senior team meetings where the organisational goals and plans are reviewed. Quality data is collated for accident/incidents, infection control, internal audits, concerns, complaints and surveys. Monthly comparisons, trends and graphs are displayed for staff information. Bi-monthly staff, quality and risk management meeting minutes sighted evidence staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The RN and caregivers interviewed were aware of quality data results, trends and corrective actions. Annual resident and relative surveys are conducted with good overall satisfaction results achieved for Golden Age in November 2016 and Camellia Court/Albarosa in March 2017. Results have been collated and results fed back to participants and staff as evidenced in each of the facilities meeting minutes (sighted).</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An internal audit programme covers all aspects of the service. Any areas for improvement are identified and implemented. A monthly summary of internal audit outcomes is provided to the staff meetings for discussion. Corrective actions are developed, implemented and signed off by the quality assurance manager. Reviews and audits are conducted more frequently where issues are identified. There is a health and safety and risk management system in place including policies to guide practice. The facility managers are responsible for non-clinical accident/incident investigations. There are current hazard registers. Staff confirmed they are kept informed on health and safety matters at staff meetings. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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>	<p>FA</p>	<p>Eighteen accident/incident forms for the month of October 2017 were reviewed in total, six accident/incident forms reviewed for each of the three facilities. There has been RN notification and clinical assessment completed within a timely manner in the sample of six accident/incident forms reviewed. Accidents/incidents were also recorded in the resident progress notes. The service reports aggregated figures to the staff meeting and the quality and risk management meeting. Staff interviewed confirmed incident and accident data are discussed at the staff meeting and information and graphs are made available. Discussions with the facility managers confirmed an awareness of the requirement to notify</p>

		relevant authorities in relation to essential notifications. There have been five section 31 notifications since the last audit. In relation to two residents absconding (January and October 2017), one missing persons (February 2017), one unstageable pressure injury (July 2017) and one unexpected death in (February 2017).
<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>Human resources policies include recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one group clinical manager, one facility manager, one RN, one cook, one diversional therapist and three caregivers) contained all relevant employment documentation. Current practising certificates were sighted for the RNs and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. Staff interviewed advised that new staff were adequately orientated to the service on employment.</p> <p>There is an annual education and training schedule in place for 2017 and a completed annual education and training schedule for 2016. Three of five RNs have completed interRAI training, plus the clinical managers in each area. There are competencies for RNs related to specialised procedure or treatment. Residents and families state that staff are knowledgeable and skilled. There are 47 caregivers (21 in Camelia Court and 26 in Albarosa) employed across the dementia facilities. Forty-three have completed the required dementia unit standards and three are in the process of completion. The one caregiver that has not completed has been employed for less than six months.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery included in the rostering policy. Care staff reported that staffing levels and the skill mix was appropriate and safe. Residents and family members interviewed advised that they felt there was sufficient staffing. The service has a staffing levels policy implemented, which determines that there is a RN on duty or on call at all times and that at least one staff member on duty holds a current first aid qualification. New staff must be rostered on duty with an experienced staff member during the orientation phase of their employment. These standards are evident on review of the weekly rosters and discussions with staff. Advised that the roster is able to be changed in response to resident acuity. The facility managers each work 40 hours per week and are available on call 24/7</p>

		<p>with the support from the group clinical manager.</p> <p>In the Golden Age rest home facility there are 53 rest home level residents. There is one RN on duty on the morning shift. Four caregivers are on duty in the morning and on the afternoon shifts, and two caregivers on duty on the night shift.</p> <p>In the Camellia Court dementia facility there are 33 dementia care level residents. There is one RN on duty on the morning shift. Four caregivers are on duty on the morning and on the afternoon shifts, and two caregivers on duty on the night shift.</p> <p>In the Albarosa dementia facility (two units of 20 beds) there are 40 dementia care level residents. There is one RN is on duty on the morning shift. In total there are five caregivers on duty in the morning and four caregivers are on duty on the afternoon shifts, and two caregivers on duty on the night shift. In addition, there are another two full-time RNs that float between the three facilities. Diversional therapists provide the activities programme in the rest home and the two dementia care facilities.</p> <p>All the homes are connected as one facility on the same site.</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>	<p>FA</p>	<p>The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. Resident records containing personal information are kept confidential. Entries were legible, dated and signed by the relevant caregiver or RN. All records and resident file entries record the staff members name and designation. The previous partial attainment has been addressed.</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 uses individualised medication blister packs and an internet based electronic medication system. On interview, the RNs reported that prescribed medications are delivered to the facility and are checked in on delivery. Medications and associated documentation were stored securely. Medication competent caregivers were observed administering medications correctly. The medication fridge temperatures are recorded. Resident photos and documented allergies or nil known were on all 16 medication charts reviewed. An annual medication administration competency is completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating resident's policy and procedure in place, with one rest home resident assessed as competent to self-administer medications. Competency assessments are reviewed three monthly. Medications are reviewed three monthly with medical reviews by the attending GP. Medication charts</p>

		provide a record of medication administration information. Signing sheets were fully completed. Medication charts with 'as required' medication charted recorded indications for use. 'As required' medication is reviewed by a RN each time prior to administration. There were no standing orders in use. The previous partial attainment has been addressed.
<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>	PA Low	<p>All meals are prepared and cooked on-site in two kitchens. One large kitchen provides meals to rest home and retirement village residents. The other kitchen is located between the two dementia facilities and services both units. A five-weekly winter and summer menu has been reviewed by a dietitian in April 2016. The fridge, freezer and hot food temperatures were being recorded. End-cooked food temperatures are recorded on each meal. The dishwasher is checked regularly by the chemical supplier. Not all foods were date labelled and stored correctly. The service employs cooks who have relevant food safety qualifications.</p> <p>Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen, via the RNs or facility managers. Staff were observed assisting residents with their meals and drinks. Diets are modified as required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. Family meetings and the next of kin surveys allow for the opportunity for feedback on the meals and food services generally. Residents and family members interviewed indicated satisfaction with the food service. The kitchen service stated that residents often give verbal feedback.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	Residents' long-term care plans reviewed were resident-focused and individualised. Care plans did not always document the required supports/needs to reflect the resident's current health status. Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Care plans are reviewed three monthly and updated to reflect changes to supports/needs. Short-term care plans were sighted for short-term needs and these were either resolved or transferred to the long-term care plan. There was evidence of allied health care professionals involved in the care of the resident.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate</p>	PA Low	Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met. When a resident's condition alters, the RN initiates a review and if required a GP visit. Faxes to the

<p>services in order to meet their assessed needs and desired outcomes.</p>		<p>GPs for residents' change in health status were sighted in the resident's files in the VCare system. Dressing supplies are available and treatment rooms in each facility were stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management and documented continence products identified for day use, night use and other management.</p> <p>The GP documentation and records were current. Specialist continence advice is available as needed and this could be described. Wound assessment and wound management plans were in place for twenty-one residents, six of whom had more than one wound. There is a shortfall around wound evaluations in one dementia unit. The RNs interviewed advised that they have access to external wound specialists as required. Progress notes and observation charts are maintained. Staff confirmed they were familiar with the current interventions of the residents they were allocated.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The diversional therapy team plans for the provision of the activities programme over seven days each week. Two diversional therapists have completed the level four diversional therapy course and have completed the dementia unit standards. One activities coordinator has commenced the diversional therapy training.</p> <p>Across the dementia units there is one activity coordinators five days a week and two activity coordinators 37.5 hrs per week The programme is planned monthly and residents receive a personal copy of planned monthly activities. There is a set activity programme that is resident-focused and is planned around meaningful everyday activities such as exercises, bowls, group walks, reminiscing, van outings, children's school and dancing group visits, church services and baking. Activities planned for the day were displayed on noticeboards around the facility. The activities plan's reviewed had been evaluated at the same time as the care plans in resident's files sampled. A 24-hour diversional therapy plan has been developed for each individual resident based on assessed needs.</p> <p>Residents are encouraged to join in on activities that were appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used at least weekly for each area for resident outings. The outings include visits to community functions. Residents were observed being encouraged and participating in activities on the days of audit. Two to three monthly family meetings and the next of kin survey provide a forum for feedback relating to activities as well as resident verbal feedback. Family members interviewed discussed enjoyment in the programme and the diversity offered to all residents. There are specific activities programmes in place for each of the</p>

		dementia units and the rest home. The dementia unit programmes are relevant to residents with cognitive and behavioural deficits and cater to individual resident needs. Each unit has its own diversional therapist or activities coordinator.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Where care plan evaluations have been completed, a reassessment of the interRAI assessment tool has been completed and reflects the needs of the resident. Long-term care plans reviewed were updated as changes were noted in care requirements. Long-term care plan evaluations recorded the degree of achievement of goals and interventions. Short-term care plans are utilised for residents and any changes to the long-term care plan reviewed were dated and signed. Care staff document progress notes on every shift. There is evidence of GP contact when a resident's condition changes. There was recorded evidence of additional input from professionals, specialists or multidisciplinary sources. This previous partial attainment has been addressed.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed at each facility, which expires on 1 July 2018.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Moderate	A fire evacuation plan is in place approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation practice documentation was sighted. A contracted service checks all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back-up power for emergency lighting is in place. On the day of the audit a fire exit was locked.
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	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The GHG infection control nurse collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs with support from the GHG quality assurance manager. Monthly infection data is collected for all infections based on signs and symptoms of infection. Individual resident infection forms are completed, which includes signs and symptoms of infection, treatment, follow-up, review and

		resolution. Surveillance of all infections is entered onto a monthly facility infection summary and staff were informed. The data has been monitored and evaluated monthly and annually at facility and organisational level. Systems are in place that are appropriate to the size and complexity of the facility. An outbreak in June 2016 was appropriately managed with notification made, extra resources provided, appropriate management of staff, residents and families and a debriefing post incident.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by the group clinical manager. There are currently no residents requiring restraint and no enablers.

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 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>	PA Low	Dried foods including cereals, herbs, spices and baking ingredients had been decanted into airtight storage containers. No dates were documented on the containers.	Expiry dates were not documented on storage containers when food was evidenced to have been decanted from original container.	<p>Ensure food containers document the expiry date of food.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Low	The RN is responsible for the development of the care plans. Information gathered during admission was not reflected in the initial care plan in all files sampled. Not all information gathered through the use of the interRAI was transferred to the long-term care plan. Short-term care plans were in use but not for all changes in health conditions.	<p>i) One of three initial care plans reviewed (the RH respite resident) did not document that the husband was in the same facility.</p> <p>ii) One of three RH residents with an acute change in health condition did not include the dietitian’s requirement for weekly</p>	<p>Ensure care plans include, and are updated to include interventions for all assessed needs.</p> <p>90 days</p>

			weighs. iii) One of five dementia residents long-term care plans had not been updated to document a change from independent mobility to requiring a hoist (resident at Camelia Court recently reassessed for higher level of care).	
<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	Staff interviewed described interventions to evidence that residents are receiving appropriate care. All wounds had an initial full assessment and management plan documented. Timeframes were not always met for evaluations.	Evaluations had not been completed at the required frequency for seven of thirteen wounds in Albarosa dementia unit.	<p>Ensure all wounds are redressed and evaluated at the documented frequency.</p> <p>90 days</p>
<p>Criterion 1.4.7.1</p> <p>Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>	PA Moderate	The service has a fire evacuation plan and regular six-monthly fire drills. Staff interviewed were aware of the need for fire exit access to be available at all times. Due to concern in a dementia unit around residents absconding while contractors were on-site, a fire exit door had been locked. Since the draft report the provider has purchased a small fire box with a key in it that sits on the wall beside the door. There are directions to break the glass to access the key.	One fire exit door in the Albarosa dementia unit had a deadlock attached and was locked on the day of audit.	<p>Ensure all fire access doors are able to be opened at all times.</p> <p>7 days</p>

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.