

Thornton Park Retirement Lodge Limited - Thornton Park Retirement Lodge

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 HealthShare 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:	Thornton Park Retirement Lodge Limited
Premises audited:	Thornton Park Retirement Lodge
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 October 2017 End date: 27 October 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:	37



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

Thornton Park can provide care for up to 42 residents. This unannounced surveillance audit was conducted against the Health and Disability Service Standards and aspects of the service contract with the District Health Board (DHB).

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and one medical officer.

Most requirements identified at the previous audit have been met. These include improvements in relation to advance directives; integration of resident records; some aspects of the quality programme including documentation of adverse events, meetings, risk assessments, internal audits, corrective actions, adverse events; assessments completed by a doctor; documentation of interventions; medication management; food services; and calibration of medical equipment.

Requirements are still required to some aspects of the quality programme including organisational plans and policies and procedures; staff training and documentation of assessments.

A further improvement identified at this audit is required to completion of performance appraisals.

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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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents demonstrates they are provided with adequate information and that communication is open.

Communication records are maintained in each resident record. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. The complaints register is current.

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.		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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The clinical nurse manager provides operational management with support from the support administrator. There is a documented quality and risk management system that supports the provision of clinical care and support. Policies are in place and quality and risk performance is reported through meetings. The quality and risk management programme includes analysis and discussion of incidents with an internal audit schedule implemented.

There are human resource policies implemented around selection of staff and orientation. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

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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Service provision is coordinated to promote continuity of service delivery. The residents and family interviewed confirm that they have input into care planning. Resident care planning is changed according to the needs or when progress is different from expected. The service uses short-term care plans for acute problems.

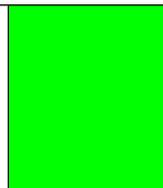
The residents and family interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is a secure medicine system in place. Registered nurses administer medication, and all have a current medication management competency.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are 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.

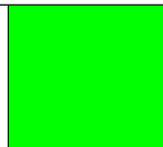


Standards applicable to this service fully attained.

All building and plant comply with legislation with a current building warrant of fitness in place. Equipment is tested annually with electrical checks occurring. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. Residents have access to outdoor areas that are safe.

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.

The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There residents using enablers on audit days with monitoring by staff in place when enablers are used.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The policies and procedures guide staff in areas of infection control practice. The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided.

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	1	3	0	0
Criteria	0	42	0	1	3	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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There is an informed consent policy in place. Consent is included in the admission agreement and sought for activities. Staff seek verbal consent for interventions as part of daily service delivery.</p> <p>Staff interviewed demonstrate an understanding of informed consent processes.</p> <p>Residents and relatives confirm that they are provided with opportunities to give consent for interventions. All resident records reviewed include written consent for care to be provided, for outings, sharing of information and for photographs to be used.</p> <p>All residents have the choice to make an advance directive with a policy in place describing the process for documentation. The process for recording an advance directive has been changed following this being raised as an issue at the previous audit. If a resident is deemed not competent to make an advance directive, then this is documented by the general practitioner with no further documentation required. If the resident is deemed competent, then this is recorded and the resident is able to record whether they wish to be resuscitated or not. The advance directive is retained on file, reviewed annually and only put into practice if the resident is no longer able to make that decision. The improvement required at the previous audit has been met.</p>
<p>Standard 1.1.13: Complaints</p>	FA	<p>The complaints management policy and procedure is documented and follows Right 10 of the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). The</p>

<p>Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>complaints policy and procedure is explained by the clinical nurse manager or the support administrator as part of the admission process.</p> <p>There are complaint forms available at the main entrance to the building. Residents' complaints are managed by the clinical nurse manager or support administrator. An up-to-date resident complaints register is maintained. A complaint was tracked prior to the last audit with this resolved in a timely manner as per policy. Staff, residents and families interviewed have a good understanding of the complaints process.</p> <p>There have been no complaints internal complaints, or complaints from external authorities since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The service has policies covering communication, access to interpreters and the clinical nurse manager and support administrator maintain an open-door policy that encourages residents and family to talk with them if there are issues. Information is provided in a manner that the resident can understand as confirmed by residents interviewed. Resident meetings are held two monthly and family are encouraged to attend.</p> <p>The incident and accident forms include an area to document if family have been contacted with all reviewed indicating that family are contacted when an incident has occurred. Open disclosure is practised and documented when family are contacted as per policy.</p> <p>Residents and relatives interviewed confirmed that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirm that they are advised if there is a change in their family member's health status. The general practitioner (GP) interviewed reported satisfaction with communication by staff.</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>PA Moderate</p>	<p>The organisation is privately owned. The service provides for residents requiring rest home or hospital level of care with 18 residents requiring rest home level of care and 19 requiring hospital level care on the days of audit. There were no residents supported through respite care on the days of audit.</p> <p>The mission statement and values are documented and known to staff, residents and family members. Organisational plans such as the strategic plan and organisational risk management plan are to be reviewed and documented for the current year and the improvement required at the previous audit remains.</p> <p>Organisational performance is monitored by the clinical nurse manager and support administrator with support from the owner as required.</p> <p>The clinical nurse manager is responsible for ensuring services are planned, coordinated and appropriate to meet the needs of the residents. The clinical nurse manager is a registered nurse with a current practising certificate and has been in the role for over eight years. The clinical nurse manager has over 20 years' experience in aged</p>

		<p>care, and has management training through an external association annually.</p> <p>The clinical nurse manager has completed at least eight hours of education in the last year to maintain their practising certificate.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Moderate</p>	<p>The quality and risk management programme is documented and identifies objectives for the service (refer 1.2.1.1). Activities within the quality and risk management programme include health and safety, adverse event reporting, infection prevention and restraint minimisation. There are policies in place that have been reviewed at least two yearly however documentation of links to legislation and evidence continues to be required. Policies are also required to include reference to changes in practice such as interRAI, Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 and pressure injuries. A document control system is implemented. The improvement required at the previous audit has been met.</p> <p>Quality related data and outcomes are collated with information documented in meeting minutes. There are monthly or two monthly meetings held to discuss issues with documentation in meeting minutes evidencing clinical review and discussion. The improvement required at the previous audit has been met. Meetings include the following: quality; coordinator meeting (including heads of departments such as kitchen, nursing, health and safety, housekeeping); registered nurse meeting, caregiver meeting; (three monthly meetings) and kitchen meeting. Meetings with laundry staff are held when required. Staff interviewed describe understanding and implementing the quality and risk management programme. There are three to four monthly resident and family meetings with evidence of discussion. Corrective action plans are documented and there is evidence of resolution. The improvement required at the previous audit has been met.</p> <p>There is an internal audit schedule that is implemented with risk assessments documented. These include risk assessments of areas of service delivery such as human resources, food services, security, restraint, falls, manual handling, infection control, emergency services, waste management and resident potential abuse or neglect. The risk assessments have been reviewed. This includes a review of resident files. The improvements to the review of risk assessments and internal audits of resident files required at the previous audit has been met.</p> <p>Health and safety requirements, including hazard identification, is discussed at the coordinator and other meetings. Managers, staff, residents and family can describe input into the health and safety programme through relevant meetings and through discussions with the clinical nurse manager or support administrator.</p> <p>Residents and family have a wide range of mechanisms available that support them to have input into service delivery and organisational improvement. This includes a six-monthly visitor experience survey; a care evaluation survey and a food service survey. All indicate that there is a high level of satisfaction with the service. A gazette is sent to family two monthly with this available to residents.</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>There is an established system in place for managing adverse events (both clinical and non-clinical). A review of the adverse event reporting system confirmed that incidents and accidents are being reported. Any incidents documented in progress notes are recorded using the incident reporting process. The improvement required at the previous audit has been met.</p> <p>The incident forms that have been completed show evidence of immediate responses, investigations and remedial actions being implemented as required. Incidents that are unwitnessed or that include an injury to the head show that neurological recordings are taken for a sustained period. This includes reporting to family members and informing the general practitioner. The general practitioner confirmed that they are informed of any incidents in a timely manner. The review confirmed that documented incidents and accidents were closed in a timely manner with actions taken to address issues raised. Actions included taking and recording of neurological observations. The improvement required at the previous audit has been met.</p> <p>The clinical nurse manager understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. Reporting has been completed as per contractual specifications with a pressure injury identified prior to the last audit now reported to HealthCERT using a section 31. The improvement required at the previous audit has been met.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>PA Moderate</p>	<p>There is an established system in place for human resource management.</p> <p>All staff records reviewed include an employment agreement and a position description. Staff have criminal vetting prior to appointment and professional qualifications are validated. All staff receive an orientation and participate in ongoing education when this is offered. Training related to clinical practice and care is not routinely provided. The improvement required at the previous audit remains. A training plan is not documented for the current year and an improvement is required. Performance appraisals are not completed for all staff who have been employed for 12 months or more on an annual basis and an improvement is required.</p> <p>There is a registered nurse in charge on each shift. Files of registered nurses reviewed hold current first aid certificates. The clinical nurse manager and one registered nurse are interRAI competent. Medicines are given by registered nurses and caregivers who have been assessed as competent. Staff administering medicines maintain competency which is assessed annually by a registered nurse who has been assessed as competent. Staff participate in meetings and confirm that they are kept up-to-date on changes occurring within the service or matters of concern through handover and open dialogue with the clinical nurse manager.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	<p>FA</p>	<p>The process for determining provider levels and skill mix is defined in policy and considers the layout of the facility and levels of care provided. The clinical nurse manager develops staff rosters. Rosters and staff interviewed and observation on the days of audit confirmed there are sufficient numbers of staff in each wing to meet needs of</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>each resident. Registered nurses are on duty each shift and are supported by caregivers including staff who have been working in the service for over 10 years. The clinical nurse manager is on site Monday to Friday and on call for clinical emergencies/concerns. The clinical nurse manager lives on the same site as the rest home and hospital and they state that they would respond immediately in the event of an emergency.</p> <p>The service has a full complement of registered nurses with a registered nurse on each shift. There are four caregivers on the morning shift (with an extra two staff who work four hours only); two caregivers in the afternoon with two other caregivers who work four hours each over busy times and one caregiver overnight. The clinical nurse manager has a matrix that adjusts staffing levels to numbers of residents. The clinical nurse manager and staff state that extra staff are rostered onto shifts or brought on if acuity of residents increases.</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>Paper-based resident records are maintained for each resident. All records are maintained confidentially. The resident records are stored in a locked cupboard in the nurse's station with other information kept in the clinical nurse manager's office and in the support assistant's office. The files record information for ongoing care and support being provided. Records are now integrated with archived records kept in a sequential manner. The improvement required at the previous audit has been met.</p> <p>Staff have a password to access any electronic files with a back of information kept off site.</p> <p>A record of past and present residents is maintained electronically. InterRAI assessments are completed by the registered nurses and inform the development of the resident's plan of care (refer 1.3.4). Progress records are clearly documented by the staff in the paper-based record. The date, time, signatures and designation of those entering into the records is legible.</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>There is a secure room that holds any medicines, including controlled drugs. The room ensures that medicines are kept in a cool area that has sufficient light, with medicines stored in original dispensed packs.</p> <p>The controlled drug register is maintained and evidenced weekly checks. Six monthly physical stock takes are conducted. The improvement required at the previous audit has been met. There are no residents requiring the use of controlled drugs currently.</p> <p>The medication fridge temperatures are taken weekly and recorded. The temperatures reviewed are within normal range as per policy.</p> <p>There is a medication management policy that requires review (refer to 1.2.3).</p> <p>All staff authorised to administer medicines have current competencies. The medication round observed indicates that staff members are knowledgeable about the medicines administered and administration is signed off as soon</p>

		<p>as the dose has been administered. Staff education in medicine management is conducted annually.</p> <p>Resident medication records include photo identification with the original photograph signed and dated as a true and correct likeness in the resident record. The improvement required at the previous audit has been met.</p> <p>As required (PRN) medication is identified for individual residents and indications of use are recorded. The improvement required at the previous audit has been met. Three monthly medicine reviews are completed. The improvement required at the previous audit has been met. Discontinued medicines are signed off and dated indicating that these are no longer required. The improvement required at the previous audit has been met. There are no residents self-administering medicines at the facility.</p>
<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>	FA	<p>The food service policies and procedures require review (refer to 1.2.3). There is a four-week seasonal menu reviewed by a dietitian in 2017. The kitchen coordinator oversees food services and ensures that staff are familiar with how to cook each meal.</p> <p>Kitchen staff are aware of the residents' individual dietary needs with these documented clearly in the kitchen. Documentation of dietary needs for any new resident is provided by the registered nurse to the kitchen staff with this observed as occurring in the kitchen on the day of audit. The residents' dietary requirements are identified, documented and reviewed on a regular basis.</p> <p>The residents' records demonstrate monthly monitoring of individual resident's weight. Resident records evidence residents' dietary intake monitoring. In interviews, residents state they are satisfied with the food service. They report that their individual preferences are met, and adequate food and fluids is provided. The food satisfaction survey completed six monthly confirms a high level of satisfaction with food services.</p> <p>The fridge, chiller and freezer temperatures are recorded. Food temperatures are taken once a week with temperatures within normal range as per policy. Decanted foods are dated. Pantry selves meet infection control standards. The improvement required at the previous audit has been met.</p> <p>Kitchen staff are aware of kitchen cleaning requirements and interviews confirmed a cleaning schedule is followed. While this list of tasks is not signed off, the kitchen coordinator monitors this daily. The kitchen was observed to be clean and tidy on the days of audit. There is no evidence of peeling paint on pantry shelves. The improvement required at the previous audit has been met.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements,</p>	PA Low	<p>The service has processes in place to seek information from a range of sources. These include access, for example to family; general practitioner; specialists and referrer, as confirmed at staff interviews. Residents' files document the required initial assessments which are completed on admission or reviewed when required in both rest home and hospital resident records.</p>

<p>and preferences are gathered and recorded in a timely manner.</p>		<p>The residents' files evidence residents' discharge/transfer information from the district health board (DHB), when required. Residents' assessments are conducted in the resident bedrooms or in a private space.</p> <p>Two residents admitted since the last audit have not had an interRAI assessment completed within the first three weeks of admission. The improvement required at the previous audit remains. Each resident has specialised risk assessments completed as part of the initial assessment period and a full nursing assessment completed. All specialised risk assessments and the interRAI assessments are completed at six monthly intervals. The resident records reviewed indicate that the following is now completed: pain assessments for residents experiencing pain; pressure area risk assessments; wound assessments and wound care plans for any resident with a wound.</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>The residents' care plans evidence detailed interventions based on assessed needs (refer 1.3.4) and desired outcomes or goals of the residents. When issues are identified on a risk assessment, then these are transferred to a short-term care plan or to a wound management plan. There are no residents with wounds currently however records of residents who have had a wound in the past year were reviewed and these indicate that good practice is consistently followed. Each resident has a wound assessment; management plan and documentation of review of progress. Resolution is signed off when the issue has been resolved. The improvements required at the previous audit related to documentation of interventions has been met.</p> <p>The documentation and records completed by the general practitioner are current.</p> <p>In interviews, residents and family confirm their and their relatives' current care and treatments meets their needs.</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>An activities officer implements an activities programme four days a week for seven hours a day. They are also available to offer activities on other days if required.</p> <p>Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are completed by the activities officer, with dates of entry and signatures documented.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data and includes opportunities for spiritual and cultural connections. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate. Individual activities are offered.</p> <p>The activities officer reported that residents have opportunities at resident meetings to discuss activities they would like included in the programme. This is evidenced in sighted resident meeting minutes. Residents were observed to enjoy activities offered during the audit. Activities are voluntary and this was evidenced on audit days with some residents choosing not to engage in the planned activities. Residents' attendance records are</p>

		maintained and the activities officer records resident involvement in the activities programme in the progress notes.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' care plans are current and reviewed six monthly. Care plan evaluations are documented and record the degree of achievement to the interventions provided.</p> <p>The residents' progress records are entered on each shift. When resident's progress is different than expected, the registered nurse contacts the general practitioner. The general practitioner confirms that any needs are escalated in a timely manner.</p> <p>Short term care plans and wound management plans are recorded when required and reviewed in a timely manner. The improvement required at the previous audit has been met. The family are notified of any changes in resident's condition as confirmed through family interviews.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building has a current warrant of fitness. There is a proactive approach to maintenance with no issues identified during the days on audit. Planned and reactive maintenance is implemented by the maintenance staff and contractors.</p> <p>The physical environment internally and externally is maintained to minimise risk of harm, promote safe mobility, aid independence and is appropriate to the needs of the current residents.</p> <p>The electrical equipment is checked, and records maintained with this including testing of resident property. Testing and calibration checks of medical measuring equipment has occurred within the last year. The improvement required at the previous audit has been met.</p> <p>The service can transport residents to appointments and other engagements if required.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control</p>	FA	<p>The infection control coordinator (clinical nurse manager) is responsible for the surveillance programme. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated monthly. Surveillance is appropriate for the size and nature of the services provided.</p> <p>The number of infections is documented in the registered nurse meeting minutes and discussed. Data and discussion is also evidenced in coordinator and caregiver meetings as relevant to the meeting attendees. Infections are investigated, and appropriate plans of action are sighted in meeting minutes.</p> <p>Staff confirm that they are made aware of any infections of individual residents by way of feedback from the</p>

programme.		registered nurses, verbal handovers and progress notes. This was evidenced during attendance at the staff handover and review of the residents' files.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	<p>The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded, however the policy requires review (refer to 1.2.3). There are residents at the facility using enablers and residents using restraint at time of audit. There is evidence that staff use strategies to minimise restraint and restraint practices are the last resort.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</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 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Moderate	There is a partially documented strategic, business and quality plan that includes goals for the service. There is also an organisational risk management plan that identifies key risks and strategies to mitigate or eliminate risks. The clinical nurse manager states that these are currently with the owner to review and develop further.	The organisational plans are not detailed sufficiently to include actions, accountabilities and timeframes with evidence of review at regular intervals. The improvement required at the previous audit remains and the risk rating has been raised from low to moderate.	<p>Complete documentation of current plans and review at regular intervals throughout the year.</p> <p>90 days</p>
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and</p>	PA Moderate	Policies and procedures are documented and reviewed two yearly. Links to legislation and evidence and best practice are not documented and the policies do not reflect changes in	Policies and procedures do not link to legislation and do not reflect changes in practice. The improvement	Review policies to reflect links to legislation and

procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.		practice.	required at the previous audit remains with the risk rating raised to moderate.	changes in practice. 90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	<p>In the past there has been education for staff with a record maintained of staff attendance. Some education has been offered to staff in 2015 and 2016. A training plan is not documented for 2017. The clinical nurse manager states that care staff have had training related to clinical practice however this is not documented.</p> <p>Staff have had performance appraisals annually in the past however five staff files reviewed do not indicate that these have been completed in the last year.</p>	<p>Staff have not had sufficient training over the past two years to include clinically based topics and changes to policy and procedure. The improvement required at the previous audit remains.</p> <p>A training plan for 2017 is not documented.</p> <p>Staff have not had a performance appraisal annually as per policy.</p>	<p>Review and implement the annual training plan to include clinically based topics and changes to policy and procedure.</p> <p>Document and implement an annual training plan.</p> <p>Ensure that staff have an annual training plan.</p> 180 days
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service</p>	PA Low	<p>Each resident has a nursing assessment and specialised risk assessments completed on the day of entry to the service. Ongoing specialised risk assessments are completed six monthly or when changes occur. The clinical nurse manager and a senior registered nurse are trained to completed interRAI assessments and have worked to address the lack of interRAI assessments completed at the last audit. The clinical</p>	<p>The initial interRAI assessments are inconsistently completed.</p>	<p>Provide evidence that initial interRAI assessments are completed for any new resident within</p>

delivery planning.		nurse manager is trying to put other registered nurse into training however they state that there is a waiting list for training.		three weeks of entry to the service. 180 days
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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.