

Presbyterian Support Central - Levin War Veterans

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:	Presbyterian Support Central
Premises audited:	Levin Home for War Veterans
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 5 December 2017 End date: 6 December 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:	65

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

Levin Home for War Veterans is owned by Presbyterian Support Central (PSC) and provides care for up to 80 residents at rest home, hospital and dementia level care. Occupancy on the days of the audit was 65 residents.

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

The facility manager at PSC Levin Home for War Veterans commenced the role in September 2016 and also manages the nearby PSC Reevedon facility. The facility manager is supported by a clinical nurse manager, clinical coordinator, administration team leader and a regional manager. Residents interviewed spoke positively about the service provided.

The service has addressed nine of the eleven shortfalls from the previous certification audit relating to Māori values and beliefs, service provision, assessments, care planning, interventions, evaluations and medicine management. Improvements continue to be required in relation to information management systems, and activities.

This audit has identified further improvements required around the integration of care and building warrant of fitness.

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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The service ensures effective communication with all stakeholders including residents and families. Full information is provided at entry to residents and family/whānau. The rights of the residents and/or their family to make a complaint is understood, respected and upheld by the service. Complaints and concerns have been managed and a complaints register is maintained.

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 low risk.
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PSC Levin Home for War Veterans continues to implement the Presbyterian Support Services Central quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has a documented induction programme for all roles within the service. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Resident files included medical notes by the contracted GP and visiting allied health professionals. The recreational team provide an activities programme for the residents that is varied, interesting and involves the families/whānau and community. Medication policies comply with legislative requirements and guidelines. Registered nurses and healthcare assistants responsible for administration of medicines complete education and annual medication competencies. All meals are prepared on-site. Food, fridge and freezer temperatures are recorded. Special dietary needs are catered for. Residents and family/whānau interviewed were complimentary about the food that was provided.

Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The building warrant of fitness expired on 1 September 2017. There was no current warrant of fitness for the building. Advised that it has been delayed due to three unresolved issues relating to the building, which are still to be addressed.

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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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents requiring enablers and no residents assessed as requiring the use of restraint on the day of audit.

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 is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	16	0	1	3	0	0
Criteria	0	39	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice and this is communicated to resident/family. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaint register that records activity. Complaints are discussed at the senior management team meeting and the two-monthly staff meetings. Information on making a complaint and the forms are visible around the facility. Three complaints have been made since the last audit. Follow-up communication, investigation and outcomes were documented. One complaint received in September 2017 is still ongoing. Discussion with residents and relatives confirmed they were aware of how to make a complaint.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that</p>	FA	<p>There was one resident that identified as Maori on the day of the audit. The resident's file was reviewed and had cultural beliefs and values identified. This is an improvement on the previous audit.</p>

<p>respects and acknowledges their individual and cultural, values and beliefs.</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 an open disclosure policy. Discussions with seven residents (five hospital and two rest home) and five family members (hospital) confirmed they were given time and explanation about services and procedures on admission. There are six-monthly meetings held with relatives. The facility manager, clinical nurse manager and clinical coordinator have an open-door policy. Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Twelve accident/incident forms sampled from October and November 2017 identify that family were notified following a resident incident. Interviews with four healthcare assistants (HCA), three registered nurses (RN), one clinical coordinator and one clinical nurse manager confirmed that family members are kept informed.</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>PSC Levin Home for War Veterans is part of the Presbyterian Support Central organisation (PSC) and provides rest home, hospital and dementia level of care for up to 80 residents. The hospital services are provided in three wings (Kowhai has twelve beds, Rimu has four beds and Totara Wing has fifteen beds). The rest home services are provided in two wings (Pohutakawa wing has seven beds and Kauri Wing has twenty-four beds). There is an 18-bed dementia level care unit (Matai).</p> <p>On the day of audit there were 65 residents (26 residents at rest home level including 1 resident on respite, 31 residents at hospital level and 8 residents in the dementia care). All residents were on the aged related residential care (ARRC) agreement. Across the 62-rest home/hospital beds, there are 12 dual purpose beds (6 in the hospital area and 6 in the rest home areas).</p> <p>The facility manager at PSC Levin Home for War Veterans commenced the role in September 2016 and also manages the nearby PSC Reevedon facility. The facility manager was absent during the days of the audit. The clinical nurse manager, clinical coordinator and administration team leader provide support to the facility manager. The clinical nurse manager has been in the position since August 2016 and has over 10 years' experience within the aged care industry. The clinical coordinator has been in the role for one year and has worked at the facility for five years. The administration team leader has been in the position for 10 years. The facility manager is also supported by a regional manager, who visits on a regular basis.</p> <p>PSC Levin Home for War Veterans has a 2017–2018 business plan and a mission and vision statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality and health and safety.</p>

		The facility manager and clinical nurse manager have maintained at least eight hours annually of professional development activities related to managing a care facility.
<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>	FA	<p>Presbyterian Support Central has an overall quality monitoring programme (QMP) that is part of the quality programme and includes internal benchmarking with the other PSC sites. The senior team meeting acts as the quality committee and they meet twice a month. Information is fed back to the monthly clinical focused meetings and bi-monthly staff meetings. A range of other meetings is held at the facility. Meeting minutes and reports are provided to the senior team, clinical and staff meeting, actions are identified in minutes and quality improvement forms, which are being signed off and reviewed for effectiveness. The facility manager has an understanding of the contractual agreements and requirements. The regional manager provides oversight and support to the facility manager.</p> <p>Progress with the quality programme/goals has been monitored and reviewed through the monthly senior team meetings. There is an internal audit calendar in place and the schedule has been adhered to for 2016 and 2017 (year to date). Feedback on monthly accident and incidents are provided to all meetings. The service has linked the complaints process with its quality management system, including the benchmarking programme and fed back through the senior team, clinical and staff meetings. The service has a health and safety management system, and this includes a health and safety rep (HCA) who has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly Health and Safety Committee meeting. Health and Safety Committee meetings include identification of hazards and accident/incident reporting and trends. A falls prevention strategy programme is in place that includes the analysis of falls incidents and high-risk fallers, the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>The service has policies and procedures to provide assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. An organisation policy review group has terms of reference and follows a monthly policy review schedule. New/updated policies/procedures are generated from head office. The facility manager is responsible for document control within the service; ensuring staff are kept up to date with the changes. A resident and relative satisfaction survey is completed annually. The 2017 relative satisfaction survey confirmed a satisfactory result with the service. Corrective actions were developed to address any concerns from the survey.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or</p>	FA	The service collects incident and accident data and reports aggregated figures monthly to the senior team, clinical and staff meeting. Incident forms are completed by staff, the resident is reviewed by the RN at the time of event and the form is forwarded to the clinical nurse manager for final sign off. A sample of twelve resident related incident reports (eight hospital, two rest home and two dementia level) were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care is provided following an incident. The HCAs

<p>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>interviewed could describe the incident reporting process. Discussions with the clinical nurse manager confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications and evidence of this occurring was sighted on audit. One section 31 notification was submitted to the Ministry of Health in May 2017, relating to a police investigation for a missing resident.</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>FA</p>	<p>There are human resources management policies in place, which include recruitment. Staff process requires that relevant checks are completed to validate the individual's qualification, experience and veracity. A copy of practising certificates is kept. Six staff files were reviewed (one clinical nurse manager, one clinical coordinator, one RN, one recreation officer and two HCA's). All files contained employment agreements and job descriptions. Outstanding annual appraisals had been completed and the 2017 performance appraisal schedule was being adhered to. The service is using the PSC recently introduced orientation programme that provides new staff with relevant information for safe work practice.</p> <p>The in-service education programme for 2017 is being implemented. The majority of HCA's have completed an aged care education programme. Staff attend annual compulsory study days which includes training around the Eden Alternative programme. The clinical coordinators and RN's are able to attend external training. Eight hours of education or in-service education has been provided annually. All individual records and attendance numbers are maintained. A schedule of which staff have attended education is maintained and follow-up action and sessions are offered to ensure all staff receive the required training. Five of ten RNs are interRAI trained. There are thirteen HCAs on the roster in the dementia unit and all thirteen have completed the required dementia standards.</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</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager work full-time, Monday through to Friday. The facility manager is on call for any non-clinical matters and the clinical nurse manager is on-call for any clinical issues. Advised by the clinical nurse manager that extra staff can be called on for increased resident requirements. Interviews with HCA's, residents and family members identify that staffing is adequate to meet the needs of residents.</p> <p>In the hospital area (3 wings, Kowhai, Rimu and Totara), there are 29 residents in total (26 hospital and 3 rest home residents). There is a clinical coordinator who is supported by an RN on the morning shift and two RNs on the afternoon shift and one RN on the night shift. There are six HCA's in the hospital area on the morning shift, five</p>

service providers.		<p>HCA's on the afternoon shift and two HCAs on the night shift.</p> <p>In the rest home area (two wings, Pohutakawa and Kauri), there are 28 residents in total (23 rest home and 5 hospital residents). There is an RN on the morning shift, who is supported by two HCA's on the morning and two on the afternoon shift and one HCA on the night shift</p> <p>In the dementia care wing (Matai), there are eight residents in total. There are two HCA's on the morning shift and two on the afternoon shift and two HCAs on the night shift.</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>	PA Low	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial care plan is also developed in this time. Not all amendments to care plans were signed and dated with the designation recorded and this is an area that continues to require improvement. Residents' files are protected from unauthorised access by being locked away in the nurses' stations.</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>	FA	<p>Ten medication files were reviewed (four hospital, four rest home (including one respite) and two dementia). There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration.</p> <p>Standing orders are not used and there were no residents self-medicating on the day of audit. All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly. The pharmacy and RN medication checks had been completed. The previous audit finding to these had been addressed. The medication fridge temperatures are recorded regularly, and these were within acceptable ranges. There were no residents currently self-medicating, however the RNs interviewed could describe the process.</p>
Standard 1.3.13:	FA	All meals at PSC Levin are prepared and cooked on-site. There is a five-weekly seasonal menu which had been

<p>Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>reviewed by a dietitian. Meals are delivered to the dining areas. Dietary needs are known with individual likes and dislikes accommodated with one identified exception. Pureed, gluten free and diabetic desserts are provided. Cultural and religious food preferences are met. Finger food (sandwiches, fruit and biscuits) are available in the dementia unit 24 hours a day. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally.</p> <p>Residents and family members interviewed were overall satisfied with the food and confirmed alternative food choices were offered for dislikes. Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures are recorded daily of meals before serving. All food services staff have completed training in food safety and hygiene and chemical safety.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. In the sampled appropriate assessment tools were completed including interRAI assessments. Care plans sampled were developed on the basis of these assessments and linked to the long-term care plan. Pains assessments were all well documented in medimap and linked to care plan interventions. This is an improvement on previous audit.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Five care plans reviewed (two rest home – including a respite file, two hospital and one dementia). All care plans included interventions to support current needs and medical issues. One resident file with weight loss was reviewed and included implemented interventions to manage this. One resident with behaviours that challenge included documented de-escalation techniques. Continence management was clearly documented in the interventions for the five resident files reviewed including the respite resident. Short term care plans were in use for acute changes in health status. The previous audit finding relating to documentation of interventions has been addressed.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and</p>	FA	<p>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative's health.</p> <p>In the residents' files reviewed, short-term care plans were commenced with a change in health condition and linked to the long-term support plan.</p>

<p>appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required.</p> <p>Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and specialist involvement in wounds/pressure injuries.</p> <p>On the day of audit there were 12 wounds. In the hospital there were two lesions, four moisture wounds, two abrasions and two ulcers. In the dementia unit there was a skin tear and a lesion. All wound care documentation was fully completed addressing the previous audit finding.</p> <p>There were three facility acquired pressure injuries on the day of audit and one DHB acquired PI. All were graded stage II.</p> <p>Monitoring charts were in use and sighted for behaviour monitoring, food & fluids, weight and turning charts. This is an improvement on previous audit.</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>PA Moderate</p>	<p>One member of the two-person recreation team had retired the week before audit. A replacement person was commencing the week following audit. The diversional therapist currently on staff is continuing to provide individual and group activities in the rest home/hospital and dementia care units five days per week (on weekends the care staff are allocated activities to undertake). The recreation programme is supported by a team of volunteers. The recreational programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. There are regular outings/drives and involvement in community events (including church and day-care). One-on-one activity occurs for residents who are unable or choose not to be involved in activities.</p> <p>An activity profile is completed on admission in consultation with the resident/family (as appropriate). All files reviewed had a documented recreational plan and the plans had been reviewed six-monthly at the same time as the care plans were reviewed. Activity participation was noted in the progress notes.</p> <p>The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents (as appropriate) and families.</p> <p>Relatives and residents stated they were satisfied with the activities provided. Activity plans in the dementia unit did not evidence activities across 24-hour activity plans. The previous audit finding remains unaddressed.</p>
<p>Standard 1.3.8: Evaluation Consumers' service</p>	<p>FA</p>	<p>In the residents' files reviewed, all initial care plans were documented and evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six-monthly or earlier for any health changes. The GP reviews the residents at least three-monthly or earlier if required. Evidence of three-monthly GP reviews were seen in all residents' files sampled. Ongoing nursing evaluations occur daily/as indicated and are documented</p>

<p>delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>within the progress notes. Evaluations reviewed identified that when a resident's health status had changed, interventions were updated to reflect this, and this is an improvement on previous audit.</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>	<p>PA Moderate</p>	<p>The building warrant of fitness expired on 1 September 2017. There was no current warrant of fitness for the building. Advised that it has been delayed due to three unresolved issues relating to the building that are still to be addressed.</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 programme.</p>	<p>FA</p>	<p>Policies and procedures document infection prevention and control surveillance methods. Systems are in place and are appropriate to the size and complexity of the facility. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Benchmarking occurs with fellow PSC facilities, trends are identified, and quality initiatives are discussed at RN and senior team meetings. There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. Since the previous audit, all residents had been treated prophylactically for scabies. No actual positives in residents were identified (staff only). Regional public health was notified and a Section 31 lodged.</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>There is a restraint minimisation and safe practice policy applicable to the service that complies with the Restraint Minimisation and Safe Practice Guideline 2008. The organisational policy for restraint minimisation and enabler use ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There is a restraint and enabler register.</p> <p>On the day of audit there were no residents using restraint and no residents using enablers. Staff interviews, and staff records evidence education has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques.</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 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial care plan is also developed in this time. Not all amendments to care plans were signed and dated with the designation recorded and this continues to be an area requiring improvement.	Not all alterations or amendments to the long-term care plans or wound care plans are signed dated or the designation is recorded.	<p>Ensure any alterations or amendments to the long-term care plan or wound care plans are signed and dated, and the designation is recorded.</p> <p>30 days</p>
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service</p>	PA Moderate	There was evidence that RNs could access clinical advice from incontinence and wound specialists along with the dietitian. The long-term care plans include input from allied health professionals, however this was not always documented as	Clinical nurse advice was sought from, and documented, by the clinical nurse specialist for a hospital resident with a PI, but there was no evidence of the advice being incorporated into care. There was no	Incorporate advice from clinical specialists into care planning, if advice is not appropriate/feasible

delivery and promotes a team approach where appropriate.		integrated. The previous audit finding remains	explanation as to why this was not the case.	evidence of discussion be available. 60 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Moderate	An activities assessment and a Tree of Life is undertaken for each resident and the activities programme is varied to accommodate the interests of the residents. Activity plans in the dementia unit did not evidence activities across 24-hour activity plans.	Eight of eight files of residents in the dementia unit did not include a 24-hour activity plan as per contractual requirements.	Ensure a 24-hour individual activity plan is documented for each resident residing in the dementia care unit. 60 days
Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Moderate	There was no current building warrant of fitness for the building. Three unresolved issues relating to the building are still to be addressed.	There was no current building warrant of fitness for the building. Three unresolved issues relating to the building are still to be addressed.	Ensure that there is a current building warrant of fitness. 30 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, 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.