

St Albans Retirement Home Limited - St Albans Retirement Village

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: St Albans Retirement Home Limited

Premises audited: St Albans Lifecare

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

Dates of audit: Start date: 13 June 2018 End date: 13 June 2018

Proposed changes to current services (if any): The 18-bed hospital wing was verified as suitable as dual-purpose if needed. Due to building renovations, the service has de-commissioned 11 rest home beds. This has reduced their overall bed numbers from 82 beds to 71 beds.

Total beds occupied across all premises included in the audit on the first day of the audit: 30



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 |
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|  | 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 |
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| | 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

St Albans Lifecare is owned and operated by the Arvida Group. The service provides rest home and hospital level care for up to 71 residents. This includes 53 serviced apartments/studios certified to be able to provide rest home level care. On the day of the audit, there were 30 residents in total. Due to building renovations, the service has de-commissioned 11 rest home beds. This has reduced their overall bed numbers from 82 beds to 71 beds. The service is managed by a facility manager who is supported by a clinical manager. Residents and families interviewed commented positively on the standard of care and services provided.

This surveillance audit was conducted against a subset of the 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. This audit also included verifying the 18-bed hospital wing as suitable to be used as dual-purpose.

This audit identified an improvement required around care plan interventions.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family members interviewed verified ongoing involvement with the community.

Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. | | Standards applicable to this service fully attained. |
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St Albans Lifecare is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted which generates opportunities for improvement. Corrective actions are developed and implemented. 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. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. | | Some standards applicable to this service partially attained and of low risk. |
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The registered nurses are responsible for each stage of service provision. The assessments and care plans reviewed were developed in consultation with the resident/family/whānau and evidenced allied health input. Care plans reviewed were documented in electronic records. Contractual timeframes have been met. The activity programme is varied and appropriate to the level of abilities of the residents. Medications are appropriately managed, stored, and administered with supporting documentation. Medication training and competencies are completed by all staff responsible for administering medicines. Food is prepared on-site with individual food preferences, dislikes and dietary requirements assessed by the registered nurses and a dietitian.

Safe and appropriate environment

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| Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities. | | Standards applicable to this service fully attained. |
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The service displays a current building warrant of fitness. Reactive and Preventative maintenance occurs. There have been building alterations since previous audit. There is an approved fire evacuation scheme and fire drills have occurred 6 monthly.

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.

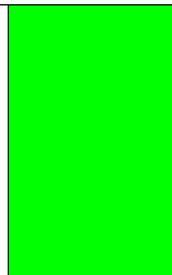


Standards applicable to this service fully attained.

The service has policies and procedures to ensure that restraint is a last resort. At the time of the audit there were no residents with restraints or enablers. Staff receives training in restraint minimisation.

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.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Surveillance data/trends and analysis is shared with staff through meetings. There have been no outbreaks since last audit.

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 | 17 | 0 | 1 | 0 | 0 | 0 |
| Criteria | 0 | 47 | 0 | 1 | 0 | 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 |
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| <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>The service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is in place. There has been one complaint made in 2017 and two received in 2018 year to date since the last audit. The complaints reviewed had been managed appropriately with acknowledgement, investigations and responses recorded. Corrective actions were established for two of the three complaints in areas where improvements were identified, both corrective actions have been completed and signed off. Residents and family members interviewed advised that they are aware of the complaints procedure and how to access forms.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p> | FA | <p>Six residents (four rest home and two hospital) interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Twelve incident/accidents had documented evidence of family notification or noted if family did not wish to be informed. Two family members (one hospital and one rest home) interviewed confirmed that they are notified of any changes in their family member's health status. Interpreter services are available as required.</p> |

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| environment conducive to effective communication. | | |
| <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>St Albans Lifecare is owned and operated by the Arvida Group. The service provides rest home and hospital level care for up to 71 residents. This includes 53 serviced apartments/studios certified to be able to provide rest home level care and 18 hospital beds. On the day of the audit, there were 30 residents in total. There were 17 rest home residents in the serviced apartments (11 on the ground floor and six on level one). In the hospital wing, there were 12 residents at hospital level care and one rest home level resident. All of the 18 beds in the hospital wing were verified at this audit as suitable to be dual purpose beds. All residents were admitted under the aged related residential care (ARRC) contact. Due to building renovations, the service has de-commissioned 11 rest home beds and the rest home wing has been replaced by a new café and kitchen. This has reduced their overall bed numbers from 82 beds to 71 beds.</p> <p>In regards to the HealthCERT dispensation letter dated 19 February 2018. Advised that this resident is no longer with the service.</p> <p>The village manager (non-clinical) is experienced in village management. The village manager manages both the St Albans Lifecare and Wendover Rest Home facilities. She has been in the village manager role at St Albans Lifecare for three years and at Wendover Rest Home since January 2018. The village manager is rostered to spend three days of the week at St Albans Lifecare and two days at St Albans Rest Home. She is supported by a clinical manager who has been in the position for two years and has worked at St Albans Lifecare for nine years. The clinical manager is full time at St Albans. There is also a quality coordinator/enrolled nurse (EN) who has been in the role since February 2018, who works one day a week at Wendover Rest Home.</p> <p>The village manager and clinical manager are supported by the general manager operations, general manager wellness and a national quality manager. The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Wendover Rest Home has a business plan for 2016–2018. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually.</p> <p>The village manager has completed in excess of eight hours of professional development in the past 12 months.</p> |
| <p>Standard 1.2.3: Quality And Risk Management Systems</p> | FA | <p>There is a business plan that includes quality goals and risk management plans for St Albans Lifecare. Interviews with staff confirmed that there is discussion about quality data at the quality, staff and clinical/RN meetings. The village manager is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. Staff interviewed could describe the quality programme corrective action process. The site-</p> |

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| <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p> | | <p>specific service's policies are being transitioned over to the Arvida Group polices, which will be reviewed at least every two years across the group. Head office sends new/updated policies and these are available to staff through the intranet. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Restraint and enabler use is reviewed within the quality and clinical staff meetings. Resident/relative meetings occur bi-monthly and the residents and family members interviewed confirmed this.</p> <p>The service has a health and safety management system that is regularly reviewed. Risk management, hazard control and emergency policies and procedures are being implemented and are monitored by the Health and Safety Committee at the monthly Health and Safety meeting. The health and safety officer (quality coordinator/EN) was interviewed. She has completed level two external health and safety training. Hazard identification forms and an up-to date hazard register (last reviewed 10 April 2018) are in place. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The overall service result for the resident/relative satisfaction survey completed in March 2018 was at 77%. Corrective actions have been established in areas where improvements were identified, ie. around food service and the corrective actions were completed in March 2018. Falls prevention strategies are in place that includes 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>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse (RN) conducts clinical follow-up of residents. Twelve incident forms (five hospital and seven rest home) reviewed for April and May 2018 demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Neurological observation forms were documented and completed for any unwitnessed falls with potential head injury. Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 incident notification completed since the last audit. The one notification was around a missing resident in November 2017.</p> |
| <p>Standard 1.2.7: Human Resource</p> | <p>FA</p> | <p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Five staff files were reviewed (one clinical manager, one RN, two caregivers and one quality</p> |

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| <p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | | <p>coordinator/EN). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>Completed orientation is on files and staff described the orientation programme. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. The village manager, clinical manager, RNs and ENs are able to attend external training, including sessions provided by the District Health Board (DHB). Discussions with the caregivers, RNs and the ENs confirmed that ongoing training is encouraged and supported by the service. Eight hours of staff development or in-service education has been provided annually. There are eight RNs and four have completed interRAI training</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> | <p>FA</p> | <p>Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 53 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager is full time and is rostered to spend three days of the week at St Albans Lifecare and two days at Wendover Rest Home. The clinical manager works 40 hours per week from Monday to Friday. The village manager and clinical manager are available on call after hours. The RN on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with residents and family members confirm there are sufficient staff to meet the needs of residents. The caregivers interviewed stated that they have sufficient staffing levels.</p> <p>Staffing is as follows; in the hospital wing there are 13 of 18 residents (12 hospital residents and one rest home resident). There is one RN on duty on the morning and afternoon shifts, and one RN on the night shift. They are supported by three caregivers (two long and one short shifts) on the morning shift, two caregivers (both long shifts) on the afternoon shift and one caregiver on the night shift. In the 53 serviced apartments there were 17 rest home level residents (11 on the ground floor and six on level one). There is one EN on duty on the morning shift, who is supported by two caregivers (both long shifts) on the morning shift, two caregivers (one long and one short shift) on the afternoon shift and one caregiver on the night shift. There is a caregiver designated for the ground floor and level one on the morning and afternoon shifts.</p> <p>The RN from the hospital wing provides emergency oversight for the serviced apartments on the afternoon and night shifts.</p> |
| <p>Standard 1.3.12: Medicine Management</p> | <p>FA</p> | <p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service has monthly blister packs that are reconciled on arrival to the facility. Medications are administered by the registered nurses and senior caregivers that complete annual competencies. Registered nurses and care staff interviewed were able to describe their role in regard to medicine administration. Medication training was last</p> |

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| <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | | <p>provided January 2018. All medications are managed appropriately in line with required guidelines and legislation. Ten medication charts sampled met all the prescribing requirements. Each drug chart has a photo identification of the resident and allergies or nil known allergies are recorded on the medication chart. There were no self-medicating residents on the day of the audit. Internal medication audits are conducted regularly. The medication charts reviewed identified that the GP had seen and reviewed the resident three monthly.</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> | <p>FA</p> | <p>All meals at St Albans are prepared and cooked on-site. Food is prepared in a recently refurbished kitchen. A new café has also recently been built adjoining the kitchen. The café is due to open this week.</p> <p>The two cooks, cook assistant and kitchen hands have all completed food safety certificates. The food control plan was verified 14/6/18. There are four weekly summer and winter menus with dietitian review. The kitchen is adjacent to the large dining rooms that is shared by residents across the facility. Some hospital residents require feeding have meals in the hospital lounge. There is also a small dining area in the apartments upstairs. Food is transported in bain maries or covered trays and served to residents. There is food available for residents outside of meal times. Residents who require special eating aids are provided for, to promote independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the RN. A dietitian visits the service as required. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. The last survey March 2018 identified a 67% outcome, this was a considerable drop from the 2017 survey. Corrective actions have been established. Interviews with residents and family members indicate satisfaction with the food service.</p> |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | <p>PA Low</p> | <p>Resident care plans reviewed were overall individualised, however not all care plans documented the specific care interventions required to meet all current assessed needs. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. There was evidence of service integration with documented input from a range of specialists. Residents and family members interviewed confirm they are involved in the development and review of care plans.</p> |
| <p>Standard 1.3.6: Service</p> | <p>FA</p> | <p>An electronic record of each resident's progress is documented. Changes are followed up by a RN (evidenced in all residents' progress notes sighted). When a resident's condition alters, the RN initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The caregivers interviewed advised</p> |

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| <p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | | <p>that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and treatment rooms are well stocked for use. There were no current pressure injuries in the facility and no current wounds in the hospital. Wound documentation was reviewed for two residents with minor wounds in the rest home. Wound documentation was included in the electronic records and a facility-wide wound register was up to date. Wound documentation included wound assessment, treatment plans and evaluations. Advised that wound care nurse specialist advice is readily available as needed.</p> <p>Dressing supplies are available and stocks available in the rest home and hospital. Contenance products are available and specialist continence advice is available as needed. Short-term care plans are used for acute short-term changes in care. Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, pain, blood glucose, food and fluid, turning charts and behaviour monitoring as required.</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>St Albans has an activity coordinator (Wellness Coordinator) that provides activities to all residents Monday to Friday (9.00 am – 4.00 pm). The Wellness Coordinator has completed Careerforce level four. There is an individualised monthly planner for each of the three areas (rest home, hospital and apartments). Group activities are voluntary and developed by the wellness coordinator. Residents are able to participate in a range of activities that are appropriate to their cognitive and physical capabilities. St Albans has its own van which is used for resident outings. The group activity plans are displayed on noticeboards around the facility. A men's group is run by a man living in the apartments and men within the rest home and hospital are supported to attend.</p> <p>All residents who do not participate regularly in the group activities are visited by the wellness coordinator ensuring all such residents are included. Records are kept. All interactions observed on the day of the audit indicated a friendly relationship between residents and the wellness coordinator. The resident files reviewed included a section of the e-case care plan for activities and is reviewed six monthly. Residents interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via the bi-monthly resident meetings and surveys.</p> |
| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p> | <p>FA</p> | <p>In the files reviewed, interRAI assessments were completed and reviewed within expected timeframes. Long-term care plans were reviewed and evaluated at least six monthly by the RNs or when changes to care occur. The GP examines the residents and review the medications three monthly. Short-term care plans focus on acute and short-term needs. Interviews with residents and relatives confirm they were involved in care planning and evaluation.</p> |

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| <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>FA</p> | <p>The service displays a current building warrant of fitness which expires on 1 August 2018.</p> <p>There is stair and lift access between the floors. Apartments are located on the ground floor and level one.</p> <p>The service employs a full-time maintenance person. The maintenance person ensures daily maintenance requests are addressed and a planned maintenance schedule is maintained. Essential contractors are available 24 hours. Electrical testing is completed annually. Annual calibration and functional checks of medical equipment is completed by an external contractor. The maintenance person carries out regular checks of transferring equipment, beds and call bells</p> <p>The 18-bed hospital wing was verified as suitable as dual-purpose if needed. Due to building renovations, the service has de-commissioned 11 rest home beds. This has reduced their overall bed numbers from 82 beds to 71 beds. In place of the rest home rooms a new kitchen, extended dining room and café has been built. Building renovations continue and all areas are currently blocked off to staff and residents.</p> <p>There is sufficient equipment as described by staff. There are outdoor areas for residents that include seating and shade.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>FA</p> | <p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service (dated 3/5/2007). Advised that the fire evacuation scheme did not require changes as a result of the renovations. A fire drill was last completed 21/3/18. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term backup power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas.</p> |
| <p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p> | <p>FA</p> | <p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. The quality coordinator (EN) is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually at facility and organisational level.</p> |

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| and methods that have been specified in the infection control programme. | | |
| Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit there were no residents with restraints or enablers Staff received training on restraint minimisation in August 2017. |

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) |
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| Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | All resident files reviewed had an electronic care plan in place. All long-term care plans have mobility and transfer care plans, nutrition, management of activities of daily living were documented well. Caregivers interviewed were able to describe the current care needs of the residents well. In three of five care plans reviewed, interventions described the care and support required for all current assessed needs. | (i)Interventions were lacking in detail to support catheter care for one hospital resident with a urinary catheter. (ii) insulin dosage/administration requirements were documented in the care plan for one rest home resident on insulin, however the dosage was different than what was charted on the medication chart (noting staff are administering correctly from the medication chart) | (i) Ensure catheter care required by staff is documented in sufficient detail in the care plan. (ii) Ensure medication requirements are not transcribed in the long-term care plan. 60 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.

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End of the report.