# Sunrise Healthcare Limited - Lynton Lodge Hospital

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Sunrise Healthcare Limited

**Premises audited:** Lynton Lodge Hospital

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Physical

**Dates of audit:** Start date: 14 November 2018 End date: 14 November 2018

**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:** 36

# 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 |
|  | 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

Lynton Lodge Hospital is certified to provide hospital (geriatric and medical) level care and residential disability services – physical. There were 36 residents at Lynton Lodge on the day of audit.

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.

There is a general manager who provides oversight of Lynton Lodge and two other facilities. The clinical manager is full time at Lynton Lodge.

The service has an established quality and risk management system. Residents and family interviewed, commented positively on the standard of care and services provided.

Four of the six shortfalls identified as part of the previous audit have been addressed. These were around: privacy during handover, medication management, water temperatures and restraint. There continues to be an improvement required around consent forms and meeting timeframes.

This audit has identified a further area requiring improvement around implementation of care.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents and family confirmed 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. Complaints reviewed are responded to and closed out in a timely manner.

## 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. |

There is a general manager and a clinical manager who provide operational management for the service.

There is an implemented quality and risk management programme. Adverse, unplanned, and untoward events are documented by staff and reviewed by the clinical manager. All aspects of the quality programme are discussed at relevant meetings.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. A staff education and training programme is embedded into practice. Registered nursing cover is provided twenty-four hours a day, seven days a week.

## 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 medium or high risk and/or unattained and of low risk. |

Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, they are evaluated six-monthly or more frequently when clinically indicated. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives reported satisfaction with the food service.

## 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. |

The service has a current building warrant of fitness.

A maintenance person has responsibility for the maintenance and repairs of the facility. There is a planned maintenance schedule in place. Electrical testing is completed annually. Clinical equipment has been calibrated. There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to the outdoor areas. Seating and shade is provided.

## Restraint minimisation and safe practice

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| 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. |

There are policies around restraint minimisation and use of enablers. 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 were no residents using enablers and three using restraint on audit day.

## Infection prevention and control

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| 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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | 2 | 0 | 0 |
| **Criteria** | 0 | 42 | 0 | 1 | 2 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | PA Moderate | The service information pack includes information regarding informed consent. The nurse manager and RNs discuss informed consent processes with residents and their families during the admission process. Resuscitation forms reviewed had not been fully completed, this is a continued shortfall from the previous audit.  The informed consent policy and procedure guides staff in the process to obtain informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care. Consent forms include van outings. All five resident files included a signed consent form; this is an improvement from the previous audit.  Interviews with staff (three healthcare assistants, three RNs and the DT) confirmed their understanding of informed consent processes. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms for lodging informal complaints (feedback) and formal complaints are readily available.  Information about the complaints process is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. Staff interviewed were also able to describe the process around reporting complaints.  A complaints register is maintained. Two complaints for 2018 were reviewed. All were fully investigated by the clinical and general manager, with evidence of resolution of issues recorded and documentation confirming that the complainant was satisfied with the outcome of the investigation also documented.  The general manager and clinical manager confirmed that there have not been any complaints from external authorities since the last audit. There have not been any cases referred to a coroner for investigation since the last audit.  Complaints received are discussed at relevant meetings.  Staff and managers were interviewed including the following: general manager; clinical manager; three healthcare assistants; diversional therapist; three registered nurses; cook; maintenance staff member. All could confirm knowledge of the complaints process and stated that they inform residents and family on entry to the service. The staff also stated that if there is a complaint, then they offer the resident or family a form to document their concerns and inform the registered nurse or clinical manager. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code.  The service ensures that each resident has the right to privacy and dignity. The residents’ own personal belongings are used to decorate their rooms. Handover is now held in a room with the door shut. Staff confirmed that this has occurred after issues were raised at the last audit. The improvement required at the last audit has been met. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney and the resident of any accident/incident that occurs. Evidence of contact being maintained with families, including when an incident or care/health issue arises, is documented on the accident/incident forms reviewed.  Seven residents (six hospitals and one rest home resident) and three family were interviewed. Interviews with residents and family confirmed that they are kept informed.  Interpreting services are available from an external provider and through staff and families.  The information pack is available in large print and this could be read to residents. Residents sign an admission agreement on entry to the service. All residents stated that they are communicated with well and informed of any changes to individual care requirements or around any incidents or accidents that occur. All stated that they can see the clinical manager at any time. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Lynton Lodge Hospital is certified to provide hospital (geriatric and medical) level care and residential disability services – physical. There are 40 hospital beds. There were 35 residents requiring hospital level of care and one resident requiring rest home level of care (dispensation discussed and approved by HealthCERT during the audit). One resident identified as requiring hospital level of care is also identified as requiring residential disability services.  There are two owners who own this facility and two other facilities. They provide input into the service with one being responsible for oversight of administration including payroll services and the other for information technology and property management. One manager visits the service during the week and can relieve for the administrator if on leave.  There is a general manager (registered nurse) who provides oversight of the three facilities. The clinical manager, general manager and staff confirmed that the owner and general manager are on site at this facility at various times during the week to support the clinical manager. Two clinical managers from other facilities supported the clinical manager and general manager on the day of audit and were interviewed as part of the audit process.  The clinical manager has a current practising certificate and has worked as a registered nurse for four years in aged care in New Zealand with one of those years identified as being the clinical manager. The clinical manager transferred from a facility owned by the same company in September 2018 after the resignation of the previous clinical manager. The CM has completed a postgraduate certificate in advanced nursing.  There is a philosophy, values and goals documented in the quality plan. Goals are reviewed weekly, monthly and annually. The philosophy is communicated to residents, staff and family through information in booklets and in staff orientation and training.  The general manager and the clinical manager have both attended a minimum of eight hours of professional development activities related to managing an aged care facility as confirmed through review of staff records. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk management programme is developed by the general manager with input from the clinical managers at the three facilities. Quality management is overseen by the organisation’s general manager and a clinical manager on site who responds to complaints received at a site level.  Policies and procedures have been reviewed last April 2018 and now are used in all three facilities including this facility. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes.  There are quality goals set for all facilities and then specific quality goals for Lynton Lodge Hospital. These particularly relate to reduction of restraint, improvement of resident care and weight management. Progress is discussed by clinical staff and managers weekly and monthly.  There are regular meetings held including monthly staff meetings, monthly registered nurse meetings and weekly clinical quality and risk meetings with all clinical managers and the general manager in attendance. There is monthly collating of quality and risk data with discussion at the clinical quality and risk meeting. Data is collated and data from other facilities owned by the same owners can be viewed to identify trends, with this discussed at the weekly clinical quality meeting with the other managers involved. This includes review of bed occupancy; audit information, complaints; incident data; high needs; admissions; staffing and clinical case review. The general manager and clinical managers have access to all the data and analysis of data.  A review of meeting minutes confirmed that quality data and results are being communicated to staff. Staff also confirmed that they are informed of any corrective actions and quality improvements. A resident and family satisfaction survey has not been completed since the change in ownership, however is scheduled for 2019. There has been a family/resident meeting held in March and May 2018.  An annual internal audit schedule is being implemented with audits completed as per the schedule. A review of internal audits confirmed that corrective action plans are completed, with evidence of resolution and sign off by the clinical manager. Corrective actions are also documented as resolved in meeting minutes.  Falls prevention strategies are being implemented. This includes the implementation of interventions on a case-by-case basis to minimise future falls. Sensor mats and physiotherapy services are utilised. The registered nurse meeting minutes and the review of the clinical quality and risk meeting minutes confirmed that clinical issues are discussed, including strategies to prevent and manage falls.  There is a health and safety plan for the service. The goals are reviewed through the health and safety meeting held quarterly for all sites with minutes of meetings documented. A health and safety representative is appointed, and they escalate any issues as these arise. Staff stated that they can also escalate issues to managers as required. Staff and clinical quality and risk management meetings confirmed that health and safety is discussed, with issues resolved in a timely manner. |
| Standard 1.2.4: Adverse Event Reporting  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. | FA | The service collects a set of data relating to adverse, unplanned, and untoward events, which is linked to the quality and risk management system. Immediate actions taken are documented on accident/incident forms now documented on Leecare (electronic database). Each incident is recorded against an individual resident, then incidents are totalled according to category. E-forms are reviewed and investigated by the clinical manager. These reviews are signed off in a timely manner by the clinical manager.  There is documentation to confirm that neurological observations are completed for any resident who has a fall involving hitting their head or for any resident who has an unwitnessed fall.  Discussions with the clinical manager and general manager confirmed their awareness of statutory requirements in relation to essential notification. The Ministry of Health has been informed of the appointment of the new clinical manager and of the previous clinical manager, and of any resident with a pressure injury if a grade three or above or unspecified. During the audit the service followed up and has received confirmation that dispensation has been given to provide rest home level of care for one resident. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Job descriptions are in place for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses and visiting health professionals are kept on file and are current.  Six staff files reviewed (the clinical manager, two registered nurses, two healthcare assistants and one diversional therapist) confirmed that there is a signed employment contract on file, a current job description and documentation of orientation and staff training.  Annual performance appraisals for staff are up-to-date. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with healthcare assistants who cover the morning, afternoon and night shifts confirmed that the orientation programme included a period of supervision over three days.  The service has a training policy and schedule for in-service education. The in-service schedule is implemented, and attendance is recorded. A system for determining staff competency is implemented. Competencies for registered nurses includes medication, syringe driver and insulin administration, and all staff complete infection control and restraint competencies. The clinical manager and two other registered nurses are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The general manager is on site during the week to provide support for the clinical manager who works five days a week (Monday – Friday).  One registered nurse is rostered onto each shift with the clinical manager taking some shifts if a registered nurse is on leave. There are six healthcare assistants in the morning (three on a short shift); four healthcare assistants on the afternoon shift (two on a short shift) and two healthcare assistants overnight. The care facility is split into three wings (east, middle west, south) and staff work in pairs, generally with five residents each. On the day of audit a further two hours has been rostered in the afternoon shift to support staff. Acuity of residents is high with all except six residents requiring two hourly turns when in bed, and support for feeding and other activities of daily living.  There is a total of 26 staff including managers. Separate staff complete laundry and cleaning duties. In total, there are six registered nurses, a diversional therapist, and sixteen healthcare assistants including two casual staff. The general manager, clinical manager and two registered nurses are rostered to provide on call services. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. The service uses a roll pack system for tablets and other medicines are pharmacy packaged. The controlled medication register was signed by two members of staff when signing out medication, this is an improvement from the previous audit. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident’s medicine order when new medicines are supplied from the pharmacy. Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Administration sheets sampled were appropriately signed. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. This is an improvement from the previous audit. There are no residents self-administering medicines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Food is prepared and cooked in the on-site kitchen. There is one cook and two relief cooks. The main meal of the day is served at lunchtime. All kitchen staff have completed food safety training. The menu has been approved by a dietitian and the food plan has been approved. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. All food is served directly from the kitchen to residents in the dining room or to their rooms as required. A tray service is available if required by residents. All food in the freezer and fridge was labelled and dated. Food procurement occurs from commercial operators. Kitchen waste is collected by commercial operators. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents’ dietary needs are communicated to the kitchen staff. Special diets can be catered. Alternative meals can be accommodated if needed. Residents’ weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | Care plans sampled were goal orientated and linked to the interRAI assessment. Not all resident interventions were fully documented in the care plans.  The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.  There were nine residents with wounds at the time of the audit. In addition, there were two grade one pressure injuries, two grade two pressure injuries and two unstageable pressure injuries. All but one of the unstageable pressure injuries were facility acquired (four residents). Assessments, management plans and documented reviews were in place for all wounds, two of the pressure injuries had two wounds per wound form. Care plans for the residents with pressure injuries all documented appropriate skin and diet interventions.  Specialist nursing advice is available from the DHB as needed. A physiotherapist is available two days during the week to assist with mobility assessments and the exercise programme.  Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.  Residents and family members interviewed confirmed their satisfaction with care delivery. |
| Standard 1.3.7: Planned Activities  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. | FA | The service employs a diversional therapist (DT) who works Monday to Friday. The DT is responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities seven days a week.  Group activities are provided indoors in the lounge, in seating areas, and outdoors in the gardens when weather permits. Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance. Individual activities are provided in residents’ rooms or wherever applicable.  On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available in the lounge, on noticeboards and in each resident room. The group programme includes residents being involved within the community with social clubs, churches and schools. Daily exercises, different cultural activities, music and song, children’s visits, and technology are features of the activities.  The DT interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan, which is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.  A record is kept of individual resident’s activities and monthly progress notes completed. The resident/family/EPOA as appropriate, is involved in the development of the activity plan. Participation in all activities is voluntary.  Lynton Lodge has its own van for transportation. A designated van driver drives the van and has a current first aid certificate. Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.  The activities programme has specific activities documented within the planner aimed at the younger resident. The activity staff explained that the activities are planned according to the preferences of the residents. The one under 65 resident is assisted to visit their home most days. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and updated. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan reviews were signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested, if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is prominently displayed.  Reactive maintenance and a 52-week planned maintenance schedule is in place that has been maintained. The hot water temperatures are monitored weekly and maintained between 43-45 degrees Celsius. There are contractors for essential services available 24/7.  The corridors are wide with handrails, and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids where required.  The external areas are well maintained. There is outdoor furniture and shaded areas. There is wheelchair access to all areas.  The caregivers and RNs interviewed, stated that they have all the equipment referred to in care plans necessary to provide care. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.  Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.  The hot water temperatures are monitored weekly and maintained between 43-45 degrees Celsius. This is an improvement from the previous audit. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control policy includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered into an electronic system. The infection control officer provides infection control data, trends and relevant information to the Infection Control Committee and clinical/quality meetings. Areas for improvement are identified and corrective actions are developed and followed up. Infection control audits are completed, and corrective actions are signed off. Surveillance results are used to identify infection control activities and education needs within the facility. There have been no outbreaks since the previous audit. |
| 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. There are three residents using hospital level of care using a restraint and no residents using an enabler.  Staff interviews confirmed that guidance has been given on restraint minimisation and safe practice, enabler use and prevention and/or de-escalation techniques. Policies and procedures include definitions of restraint and enablers. Staff education including assessing staff competency on restraint and the use of enablers has been provided within the last year.  The service has a quality goal around reducing the use of enablers and restraint. Any use has been reviewed by the general manager and clinical manager with a significant reduction recorded over the last year. The clinical manager continues to monitor use of restraint and those for whom restraint has been discontinued to ensure that safety for the resident is maintained. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | There are two residents using bedrails identified as restraint and three using enablers (one resident with both a bedrail and lap belt when using a wheelchair and the other with a bedrail). All residents using enablers restraint had an assessment and consent form signed. Risks are identified as part of the assessment process and the whole assessment and the risk of use of restraint is integrated as part of the client record on the electronic client management system. Restraint monitoring forms are completed on Lee care and two files reviewed, specifically for documentation of restraint, confirmed that these had been completed two hourly as per the directions. All use of restraint and enablers been reviewed for appropriateness of current use within the last three months.  Improvements required at the last audit to documentation of assessments, consent, risk, care planning and monitoring of restraint have been met. |

# 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.

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| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.10.4  The service is able to demonstrate that written consent is obtained where required. | PA Moderate | The informed consent policy and procedure guides staff in the process to obtain informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care. Consent forms include van outings. All five resident files included a signed consent form; this is an improvement from the previous audit. The informed consent policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders. Consent forms for resuscitation were not fully completed. | Two resident files included resuscitation forms that were incomplete; one had not been signed by the GP and one had not been fully completed | Ensure that residents have a fully documented and signed resuscitation status  60 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Moderate | The service has five registered nurses plus the clinical manager. There are two interRAI competent nurses. The service has continued to work to ensure timeframes are met and all five resident files reviewed had an up-to-date interRAI assessment and long-term care plan. New residents do not always have assessments and the long-term care plan documented within timeframes. Wound care documentation included timeframes. Assessments and evaluations have been completed (link 1.3.6.1). This is an improvement on previous audit. | (i)The initial interRAI was not completed within timeframes for one rest home resident.  (ii) The long-term care plans were not documented with timeframes for three new residents (one rest home and two hospital). | Ensure that assessments and care plans are documented within set timeframes for new residents.  60 days |
| Criterion 1.3.6.1  The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Family and residents interviewed confirmed their satisfaction with the care provided and staff were observed to be caring and attentive. All residents had a care plan in place, however not all interventions were documented, not all residents were able to reach their calls bells and wound care documentation included two wounds in two plans, making the evaluation of individual wounds unclear. | i) One hospital resident goes home most days, but this is not documented in the care plan  ii) Call bells were not in reach for five residents in their rooms.  iii) Wound care charts included two wounds per form for two resident wounds. | i) Ensure that all resident care and support is fully documented in the care plan.  ii) Ensure that all residents have a process to summon assistance if needed, or ensure that the care plan documents alternative strategies if the resident is unable to use the call bell.  iii) Ensure that each wound has its own wound care assessment and plan.  90 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, these 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.