

# Stanthom Properties Limited - San Michele Home and Hospital

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## 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 The DAA Group 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:

<b>Legal entity:</b>	Stanthom Properties Limited
<b>Premises audited:</b>	San Michele Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 3 December 2018      End date: 3 December 2018
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	26

# Executive summary of the audit

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## 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

San Michele Rest Home and Hospital provides rest home and hospital level care for up to twenty-nine residents. The service is owned and operated by Stanthom Properties Ltd and managed by a nurse manager who is supported by a senior registered nurse (RN) and a full-time administrator. There have been no significant changes to the service and facilities since the previous audit.

This unannounced surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, management, staff, and a general practitioner. Residents and families spoke positively about the care provided.

Evidence of actions to rectify the 19 findings from the previous audit, was assessed and all those non-conformances are now closed. One new finding was identified during this audit related to staff appraisals which were overdue for a majority of staff.

## 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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Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. A complaints register is maintained with complaints resolved promptly and effectively.

## 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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the owner/operators is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved, and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on good employment practice. A systematic approach to identify and deliver ongoing training to staff, supports safe service delivery. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.



Standards applicable to this service fully attained.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The processes for assessment, planning, provision of care, evaluation and exit are provided within timeframes that safely meet the needs of the residents and contractual requirements.

All residents have interRAI assessments completed and individualised care plans related to this programme. When there are changes to the resident's needs a short-term plan is developed and integrated into a long-term plan, as needed. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their relatives.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

A safe medicine administration system was observed at the time of audit.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

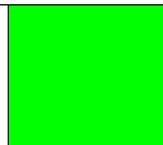


Standards applicable to this service fully attained.

There is a current building warrant of fitness.

## 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.

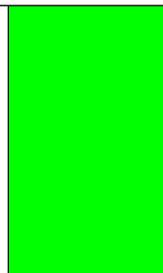


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers and five restraints were in use at the time 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.

Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

## 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)
<b>Standards</b>	0	19	0	1	0	0	0
<b>Criteria</b>	0	43	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register and associated documents reviewed showed that the one complaint received over the past year was fully investigated, and actions were taken through to an agreed resolution within acceptable timeframes. The nurse manger is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints submitted to the Office of the Health and Disability Commissioner since the previous audit.</p> <p>A documented register for recording all complaints is in place and is being maintained. The previous finding is now closed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative's status, and that they were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this has not been required as all residents are able</p>

<p>provide an environment conducive to effective communication.</p>		<p>to speak English.</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>An annual business plan with goals of the organisation is now in place. The plan outlines the purpose, values, scope, and direction. The document describes annual and longer term objectives and links to associated operational plans. This is reviewed each time the owner visits on site. The previous non-conformance related to business planning is now closed. A sample of monthly occupancy reports to the owner were reviewed and other information is provided verbally or via emails as required. The owner makes regular on-site visits at monthly intervals. Notes from these meetings confirmed that business goals and other operational matters are discussed.</p> <p>The service is managed by a nurse manager who is an RN with relevant qualifications. This person has been in the role for 14 years and was employed as the service RN three years before that. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending DHB forums for managers.</p> <p>The service holds agreements with the DHB for age related care (ARC), Long Term Chronic Health Conditions (LTCHC), Respite and Palliative care and the MoH for Young People with Disabilities (YPD)</p> <p>On the day of audit, 26 of the potential 29 beds were occupied. Seventeen residents were receiving hospital level care (two of these are under 65 years of age - one funded as YPD and the other LTCHC), and six residents were receiving rest home care. There were two additional residents on respite and one resident receiving palliative care.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>The organisation is using a sector specific quality and risk system that reflects the principles of continuous quality improvement. This includes management and reporting of incidents and accidents, complaints, internal audit activities and monitoring of outcomes, regular resident and relative satisfaction surveys, and clinical incidents including infections.</p> <p>Documents reviewed confirmed monthly review and analysis of incidents, accidents and infections. Staff meeting minutes confirmed that this information is reported and discussed at each meeting. The manager and administrator have recently met with their quality consultant and confirmed processes for quality data collection and analysis. The previous non-conformance is now closed. Staff reported their involvement in quality and risk management activities through internal audit activities. The senior RN coordinates a wide range of internal audits to be undertaken over a two month period each year and all staff are allocated areas to assess and report on. Where deficits or improvements are required, these are now documented as corrective actions on a continuous improvement form for implementation. Each action is monitored and signed off when improvement is confirmed. The previous non-conformance related to this is now closed. A comprehensive resident and family satisfaction survey is completed</p>

<p>principles.</p>		<p>annually and other surveys such as staff wellness and food satisfaction are conducted throughout the year. Areas identified for improvement from the December 2017 survey have been addressed. The most recent food survey revealed a high level of satisfaction.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The administrator is the nominated health and safety officer and is attending training for the role.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at monthly staff meetings. Incidents of high risk are reported and discussed with the owner.</p> <p>The nurse manager reported a significant theft event to the DHB on 30 January 2018. They were not advised to submit a section 31 notice to the Ministry of Health (MoH) at the time as the matter was being addressed but undertook to follow up by notifying the MoH.</p> <p>There have been no investigations by the Office of the Health and Disability Commissioner. A clinical matter referred to the DHB by a family member has been investigated and closed off.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	<p>PA Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed that APCs for the RNs, GPs and physiotherapist were current and copies are on file. The service provider has enrolled with NZ Police to facilitate police vetting of applicants but stated this is not mandatory and will only do so where this is indicated. The most recently recruited staff are new to New Zealand and have been vetted by police. The records show that referee checks had been undertaken. Job descriptions for the infection control coordinator and restraint coordinator are in</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>the senior RN's personnel record. An agreement between the Nursing Bureau and the facility was sighted. The previous non-conformances in criteria 1.2.7.2 and 1.2.7.3 are now closed.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a sixty day period. The nurse manager, who has been in the same role for 14 years, has attended a DHB day seminar for managers of aged care facilities in the past 12 months. The previous non-conformance in criterion 1.2.7.4 is closed.</p> <p>Continuing education is planned on an annual basis and includes mandatory training requirements. Each of the five RNs have current first aid certificates and have been assessed as competent to administer medicines. Attendance records confirmed that all care staff are participating in the monthly in-service training days but not all intend to progress the NZQA unit standards. There is at least eight hours of education related to the care of older people being provided each year which meets the requirement of the ARC contract. The only registered nurse trained and maintaining annual competency requirements to undertake interRAI assessments is the nurse manager. Confirmation of the cook having achieved unit standards 163 and 168 Safe Food handling was sighted. The RNs provided by the Nursing Bureau have been confirmed as competent with administering medicines from an electronic system. The previous non-conformance in criterion 1.2.7.5 is closed</p> <p>Four of the six staff files sampled did not have annual performance appraisals, on further investigation the majority of staff are overdue these. The ARCC require that all staff engage in annual performance appraisals.</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>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive</p>	<p>FA</p>	<p>The medication management policy was current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to</p>

<p>medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart.</p> <p>There were three residents who were self-administering medications at the time of audit. The previous audit identified an area for improvement to ensure that an assessment was provided to show that the resident was competent to self-administer medication. The corrective action is now addressed, and records were available to demonstrate this. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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>The food service is provided on site by one of two cooks and the kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns. The previous audit identified an area for improvement to ensure that the food menu was reviewed by a dietitian. The corrective action is now addressed, and records were available to demonstrate that the menu was reviewed by a qualified dietitian on the 27 October 2017. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by the Ministry of Primary Industries and expires 2 July 2019. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cook interviewed has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, is available.</p>

		Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional and incontinence screening as a means to identify any deficits and to inform care planning. The previous audit identified an area for improvement to ensure that all residents have assessments to support changes in their health status and to support service delivery planning. The corrective action is now addressed, and records were available to demonstrate this. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the one trained interRAI assessor on site who is the nurse manager. Residents and families confirmed their involvement in the assessment process.
Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed. The previous audit identified an area for improvement to ensure that all residents' care plans identify specific and accurate interventions related to the resident. The corrective action is now addressed, and records were available to demonstrate this. Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Any change in care required was documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care to residents was consistent with their needs, goals and the plan of care. The previous audit identified an area for improvement to ensure that all documentation reflected the daily care provided to residents by care staff. The corrective action is now addressed, and records were available to demonstrate this. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is good. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities	FA	The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy and supports residents with activities Monday to Friday from 9.00 am to 1.00 pm.

<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>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements of all ages. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions with residents and families. Residents interviewed confirmed they find the programme 'keeps them busy' and is interactive.</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>Residents' care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. The previous audit identified an area for improvement to ensure that resident short-term care plans showed evidence of evaluations. The corrective action is now addressed, and records were available to demonstrate this. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>FA</p>	<p>A current building warrant of fitness expiring in 2019 was sighted.</p> <p>New curtains have been installed for privacy in the two shared bedrooms identified as needing them at the last audit. The vinyl in the laundry is sighted as repaired and paper towel dispensers have been replaced. Repairs to the seal in the hand basin in the corridor has occurred. Rotted weatherboards have been replaced and the entire exterior of the building has been cleaned. The actions required at the previous audit have been completed. The non-conformances are now closed. Visual inspection of the interior and exterior of the facility revealed no issues. The building, plant and equipment are safe and in good working order.</p>
<p>Standard 1.4.7: Essential, Emergency, And</p>	<p>FA</p>	<p>Inspection of the civil defence kit and other emergency supplies stored on site confirmed that the service has sufficient food, water, light, heating and communication in the event of a power outage or natural disaster. The contents of the civil defence kit are listed and now checked monthly. The previous non-conformance is closed.</p>

<p>Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. The previous audit identified an area for improvement to ensure that the registered nurse with the title of infection control nurse was able to provide evidence of formal training in infection prevention and control. The corrective action is now addressed, and records were available to demonstrate formal and online training in infection control completed in 2018. Education is provided by suitably qualified RNs, and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood.</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>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/registered nurse reviews all reported infections, and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs and short-term care plans are developed. Twenty-five residents consented to having the flu vaccine in April 2018.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. The previous audit identified an area for improvement to ensure that infection surveillance data is evidenced and/or reported and discussed at staff meetings. The corrective action is now addressed, and records were available to demonstrate this. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends are identified from the past year and this is reported by the infection control nurse and reported to staff.</p> <p>The facility has had a total of 26 infections since June 2018 through to and including October 2018. One resident has been identified with three of those 26 infections due to co-morbidities. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The senior RN who is the restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her/his role and responsibilities.</p> <p>On the day of audit, five residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints. The service has reduced the number of residents requiring bed rails (from six to five) as restraints through the purchase and use of side moulded mattresses.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was confirmed by the files reviewed, and from interview with staff.</p>
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## 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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>A system for ongoing staff education is planned, documented and implemented. The topics covered are relevant to care of older people.</p> <p>Four of the six staff files reviewed had no evidence of annual performance appraisals as required in the DHB agreement. The senior RN has not had a performance appraisal for over two years. Further investigations showed that the majority of staff (24 of 30) are overdue performance appraisals by four to six months. The Nurse Manager is aware, meetings have been scheduled and an intent to complete these in the next two months was stated. The majority of staff are long term employed with no performance issues. Their ongoing training needs and competencies are known by the senior RN who coordinates the education programme.</p>	A majority of staff annual performance appraisals are overdue.	<p>Provide evidence that all staff have engaged in an annual performance appraisal.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.