

Bupa Care Services NZ Limited - Cornwall Park 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](#).

The specifics of this audit included:

Legal entity:	Bupa Care Services NZ Limited
Premises audited:	Cornwall Park Hospital
Services audited:	Hospital services - Psychogeriatric services
Dates of audit:	Start date: 17 December 2018 End date: 18 December 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:	35

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Cornwall Park Hospital provides psychogeriatric level care for up to 39 residents. There were 35 residents in the facility on the day of audit. All residents were under the specialist hospitals contract (ARHSS).

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.

The service is managed by a care home manager (non-clinical) who has had been in the role for two years. The care home manager is supported by a clinical manager (RN) who oversees clinical care. The clinical manager has been in the role for six months. The management team is supported by the wider Bupa management team including a regional operations manager.

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

Two of two shortfalls identified as part of the previous audit have been addressed. These were around dementia training for staff and care plan documentation.

This audit has identified two areas requiring improvement around: the use of covert medications and environmental upkeep of the kitchen.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service 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 interviewed verified ongoing involvement with the community.

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.		Standards applicable to this service fully attained.
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The care home manager has been in the role for two years. She is supported by a clinical manager, registered nurses, caregivers and support staff. There is a business plan with goals for the service that has been regularly reviewed. Cornwall Park Hospital has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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A comprehensive information booklet is available for residents/families at entry which includes information on the service philosophy, services provided and practices relevant to a psychogeriatric secure unit. The care home manager takes primary responsibility for managing entry to the service with assistance from the clinical manager. Initial assessments are completed by a registered nurse, including interRAI assessments. The registered nurses complete care plans and evaluations.

Care plans reviewed were based on the interRAI outcomes and other assessments. Families interviewed confirmed they were involved in the care planning and review process. There is at least a three-monthly resident review by the medical practitioner and psychogeriatric community team as required.

There is a group activity programme. Individual activity plans have also been developed in consultation with family. The activity programme includes meaningful activities that meet the recreational needs and preferences of the psychogeriatric residents.

Medicines are stored appropriately in line with legislation and guidelines. General practitioners review residents at least three-monthly or more frequently if needed. There are regular visits and support provided by the community mental health team and psychogeriatrician.

All meals are prepared on-site. Resident's individual food preferences, dislikes and dietary requirements are met. Nutritional snacks are available over a 24-hour period.

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.

A current building warrant of fitness certificate is posted at the entrance to the facility. A 52-week planned maintenance schedule is in place that has been maintained. All medical equipment has been calibrated and checked. Hot water temperatures are checked in each of the wings and records sighted evidence that temperatures are maintained at no more than 45 degrees Celsius.

Internal and external areas are maintained with gardens and outdoor seating and shade available. The outdoor area is secure with walking paths. There is wheelchair access to all areas.

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.

Restraint minimisation and safe practice policies and procedures are in place. Staff are provided with training in restraint minimisation and challenging behaviour management. On the day of audit there were eleven residents using restraint and no residents with an enabler. Restraint management processes are being implemented.

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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control officer (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Staff receive ongoing training in infection control.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	1	0	0
Criteria	0	41	0	1	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints policy describes the management of the complaints process. There are complaint forms available. Information about complaints is provided on admission. A suggestions box is held at reception. Interviews with residents and families demonstrates their understanding of the complaints process. Staff interviewed (four caregivers, one registered nurse, the cook and the maintenance person) were able to describe the process around reporting complaints.</p> <p>A complaints register is being maintained. Two complaints have been logged on the Riskman electronic database; both are documented as resolved with appropriate communication with complainants within timeframes.</p> <p>Complaints are linked to the quality and risk management system. Discussions with relatives confirms that issues are addressed promptly and that they feel comfortable to bring up any concerns.</p> <p>The DHB received a Section 31 notification of a serious event incident that had occurred at Bupa Cornwall Park. The DHB reviewed the incident and the actions taken by the provider and the issue has been resolved. Improvements since the incident have included additional gates for the secure gardens and screening for fences.</p> <p>Four other section 31 events have been recorded including two pressure injuries, one resident wandering, and one outbreak.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Three relatives interviewed stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. A quarterly newsletter is also sent to all families. Resident and family meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. The admission information includes the use of shared rooms and the special needs of a secure psychogeriatric unit. Interpreter services are available if needed.</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>Bupa Cornwall provides psychogeriatric level care for up to 39 residents. There were 35 residents in the facility on the day of audit. All residents were under the specialist hospitals contract (ARHSS).</p> <p>There is an overarching Bupa business plan and risk management plan. Additionally, Bupa Cornwall has developed annual quality and health and safety goals. Goals are reviewed regularly in the quality meetings and are updated on the goal sheet quarterly (at a minimum).</p> <p>The service is managed by a care home manager (non-clinical) who has had been in the role for two years. The care home manager is supported by a clinical manager (RN) who oversees clinical care. The clinical manager has been in the role for six months. The management team is supported by the wider Bupa management team including a regional operations manager.</p> <p>Staff and family interviewed praised the management team and staff.</p> <p>The care home manager and clinical manager have maintained over eight hours annually of professional development activities related to their respective roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality</p>	<p>FA</p>	<p>A quality and risk management programme is in place. Interviews with the managers and staff confirms their understanding of the quality and risk management systems.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed.</p> <p>An internal audit programme is in place. In addition to scheduled monthly internal audits, a facility health check is</p>

<p>and risk management system that reflects continuous quality improvement principles.</p>		<p>conducted six-monthly by an external Bupa representative. Data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints and challenging behaviours) are collated and analysed for each resident involved. Quality data and results are documented in the quality meetings and communicated to staff in staff meetings. Corrective actions are implemented where opportunities for improvements are identified. Areas of non-compliance include a corrective action plan with sign-off by a manager when implemented.</p> <p>The health and safety programme includes specific and measurable health and safety goals that are regularly reviewed. The care home manager is the health and safety officer. Health and safety meetings are held two-monthly. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed.</p> <p>Strategies are implemented to reduce the number of falls. The falls are reviewed and discussed in the two-monthly fall focus meetings. The service has reviewed falls and noted a high number were occurring in the lounge. A 'lounge nurse' role has been introduced. This person's role is to remain in the lounge and assist with the care, activities and supervision of residents in the lounge.</p> <p>Residents at risk of falling have a falls risk assessment completed with strategies implemented to reduce the number of falls. Caregiver interviews confirms that they are aware of which residents are at risk of falling and that this is discussed during staff handovers.</p> <p>Satisfaction surveys continue to be undertaken and reported in the 'Village News'. Aspects of the survey such as improvements to the resident's room, food experience and activities have been adopted as quality improvement activities for the year.</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</p>	<p>FA</p>	<p>There is an accident and incident reporting policy. Adverse events are documented on the Riskman database and investigated by the clinical manager and/or registered nursing staff, evidenced in all ten accident/incident forms reviewed. Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to minimise the number of incidents. Clinical follow up of residents is conducted by a RN. Unwitnessed falls include neurological observations.</p> <p>Discussion with the care home manager confirms her awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided. The DHB received a Section 31 notification of a serious event incident that had occurred at Bupa Cornwall Park. The DHB reviewed the incident and the actions taken by the provider and the issue has been resolved. Improvements since the incident have included additional gates for the secure gardens and screening for fences. Four other section 31 events have been recorded including two pressure injuries, one resident wandering, and one outbreak</p>

choice in an open manner.		
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources management policies in place which include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Copies of practising certificates are retained. Five staff files reviewed (two caregivers, one RN, one kitchen manager and one clinical manager) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job descriptions. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice.</p> <p>The education programme being implemented includes in-service training, competency assessments, impromptu toolbox talks and study days.</p> <p>The kitchen manager has completed a qualification in food safety and food hygiene. All kitchen staff have completed their food safety training on-site. Chemical safety training is included in staff orientation and as a regular in-service topic.</p> <p>Three of seven RNs (including the clinical manager) have completed interRAI training. The care home manager, clinical manager and staff attend external training including sessions provided by the district health board.</p> <p>All the staff employed except one who is new, have completed the dementia standards. This is an improvement from the previous audit.</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>	FA	<p>A staff rationale and skill mix policy is in place. Staff rostered on to manage the care requirements of the residents meet contractual requirements. Both the care home manager and clinical manager work full-time Monday-Friday.</p> <p>There are two registered nurses (RNs) rostered on duty on the morning and afternoon shifts, seven days per week. There is one RN rostered on night duty, seven nights per week. All the registered nurses are first aid competent.</p> <p>The RNs on the morning and afternoon shifts are supported by six caregivers who work 0700-1500 hours and four caregivers on the afternoon shift who work 1500- 2300 hours, plus an additional short shift four days a week.</p> <p>The RN on night duty is supported by two caregivers who work 2300-0700 hours.</p> <p>RN staffing meets contractual requirements for psychogeriatric levels of care. The clinical manager, along with the care home manager provide after hours on-call cover.</p> <p>Interviews with staff and family members identifies that staffing is adequate to meet the needs of residents.</p>
Standard 1.3.12:	PA	Ten medication charts were reviewed. There are policies and procedures in place for safe medicine management

<p>Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>Moderate</p>	<p>that meet legislative requirements. The service uses an electronic medication system and all medication charts sampled meet legislative prescribing requirements. The medication charts reviewed identify that the GP has seen and reviewed the resident three-monthly. There is a Bupa policy regarding covert medication, however the administration of covert medications did not always comply with the policy.</p> <p>All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. RNs interviewed described their role regarding medication administration. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy.</p> <p>The GP reviews the use of anti-psychotic medication and if required, makes a referral to the psychogeriatrician.</p> <p>Standing orders are not in use. There are no residents self-medicating.</p> <p>The medication fridge temperatures are recorded regularly, and these are within acceptable ranges.</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>PA Low</p>	<p>All meals at Bupa Cornwall are prepared and cooked on-site. There is a four-weekly seasonal menu with dietitian review and audit of menus. The menu is adapted to ensure resident's food preferences are considered. Finger foods and snacks are available for residents over a 24-hour period. Meals are prepared in a kitchen adjacent to the main dining room for serving. The cook and kitchen staff are trained in safe food handling and food safety procedures are adhered to. Adapted cutlery, sipper cups and lipped plates are available for resident use. Dietary profiles are completed on admission and likes and dislikes and any changes to dietary needs are communicated to the kitchen via the RNs. A dietitian is available on request. Supplements and fortified foods are provided to residents with identified weight loss issues. The kitchen manager (interviewed) is familiar with all residents' likes and dislikes and those residents with specific dietary needs.</p> <p>The kitchen environment is worn in places.</p> <p>Relatives reported on interview, that there are always snacks, fruit and sandwiches available for residents to eat and that these platters are replenished every two hours by care staff with supplies in the kitchen. Relatives also report that meals are well presented, and that staff assist those residents who require help with food and fluid intake.</p> <p>Since the previous audit and as part of the service quality initiatives, the service is working on a project to improve the meal experience. This has included: all serving dishes (such as plates) are now china and all tables are set for meals. The service has divided meals into two so that resident who require a high amount of assistance with meals are served and assisted first. This enables the more able resident to relax in a more home like environment and take time over meals.</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>FA</p>	<p>Long-term care plans are developed by the RNs in consultation with the resident (as appropriate), family and care staff. The long-term care plan is developed within three weeks of admission. The outcomes of interRAI assessments form the basis of the long-term care plan. Short-term care plans are used for short-term needs. InterRAI assessment notes provide evidence of family involvement in the assessment and care planning process.</p> <p>All five care plans sampled document interventions to meet the residents assessed care needs, identified current abilities, level of independence and specific behavioural management strategies. The recognition and management of seizures was documented in one care plan and risks and interventions associated with insulin use were documented in another care plan. This is an improvement from the previous audit. Staff interviewed report that they find the plans easy to follow.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents' care plans continue to be completed by the RNs. When a resident's condition alters, the RN initiates a review and if required, GP or mental health services consultation.</p> <p>All files have at least an initial physiotherapy assessment with ongoing assessments as necessary. The psychogeriatrician and mental health services are readily available as required. A dietitian, occupational therapist and speech language therapist visits by referral and a podiatrist visits residents regularly.</p> <p>The family members interviewed stated they are kept informed of the resident's health status and have the opportunity to meet with the GP or nurse practitioner if required.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management and the continence products that are required are identified.</p> <p>Adequate dressing supplies are available. Wound management policies and procedures are in place and weights are recorded at least monthly. The wound register currently includes one grade one pressure injury and four skin tears. All wound documentation reviewed was fully completed.</p> <p>There is a comprehensive range of monitoring forms available for use and these have been completed as needed.</p> <p>The care team and activities staff interviewed are able to describe strategies for the provision of a low stimulus environment.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a</p>	<p>FA</p>	<p>The activities coordinator has been in the role since April 2018, she is supported in the role by two other activities coordinators and volunteers. The activities coordinators have completed the dementia standards.</p> <p>The weekly activities programmes are displayed around the facility on noticeboards. Residents who do not participate regularly in the group activities, are visited for one-on-one sessions. All interactions observed on the day</p>

<p>consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>of the audit indicated a friendly relationship between residents and the activity coordinator.</p> <p>Each resident has a Map of Life developed on admission. The Map of Life includes previous careers, hobbies, life accomplishments and interests which forms the basis of the activities plan. The resident files reviewed included a section of the long-term care plan for activities, which has been reviewed six-monthly. The care plan includes activity over a 24-hour period which can be used to minimise, distract or de-escalate behaviours.</p> <p>Relatives interviewed spoke very positively of the activity programme.</p> <p>Caregivers assist with activities over the weekend and evenings and there is a caregiver allocated on each shift to be in the lounge to observe and monitor residents. Care staff were observed at various times through the day diverting residents from challenging or agitated behaviours.</p> <p>Since the previous audit and as part of the quality initiatives for the service, new dementia friendly activities have been purchased. Destination points have been reviewed and changed to make them more meaningful to residents.</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 residents' files reviewed, all initial care plans have been documented and evaluated by the RN within three weeks of admission. Long-term care plans have been reviewed at least six-monthly or earlier for any health changes. Evaluation includes documenting progress towards the achievement of the intended goals. The multidisciplinary review involves the RN, GP, community mental health team (as required), activities staff and family. The family are invited to attend and/or notified of the outcome. Ongoing nursing evaluations occur daily/as indicated and are documented within the progress notes.</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 certificate is posted at the entrance to the facility. There is a maintenance person who is also available on call after hours if needed. A 52-week planned maintenance schedule is in place that has been maintained.</p> <p>All medical equipment has been calibrated and checked. Hot water temperatures are checked in each of the wings and records sighted evidence that temperatures are maintained at no more than 45 degrees Celsius. All floor areas are vinyl surfaces. The corridors have hand rails. Residents were observed moving freely around the areas with mobility aids where required. The external areas are maintained with gardens and outdoor seating and shade available. The outdoor area is secure with walking paths. There is wheelchair access to all areas. Doors to the outdoor area have a coded keypad access. The service has a quiet lounge with stable doors. The lower door can be locked. Later in the afternoon, immobile residents that require a quieter space are moved into this lounge so as not to be disturbed by wandering and agitated residents. During this time, the lower stable door is locked, and top half of the door is open, so residents can be sighted easily. One caregiver is assigned to oversee both lounges at all times.</p>

		<p>Since the previous audit and as part of the quality plan, the service has embarked on a process to personalise and improve resident rooms. This has included wall papering walls and posting up family pictures for residents. The staff inform that due to some families not being able to visit, these homely touches are improving the lives of the residents in their care.</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>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Infections are included on a monthly register and a monthly report is completed by the infection control officer. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is collated monthly. Meeting minutes are made available to staff.</p> <p>Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control officer. Infection control data is collated monthly and discussed at the staff meetings. The infection control programme is linked with the quality management programme.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GPs and geriatrician that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There has been one outbreak reported since the previous audit, all relevant authority were informed including a section 31 notification.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a regional restraint group at an organisation level, which reviews restraint practices. There are clear guidelines in the policy to determine what restraint is and what an enabler is. The restraint policy includes comprehensive restraint procedures.</p> <p>There were eleven residents requiring the use of a restraint and there are no residents requiring the use of an enabler. One restraint is for a lap belt and ten for hand holding restraint. All restraint use is recorded on a restraint register.</p> <p>Two files were reviewed for restraint (one lap belt and one handholding restraint). Both files included the restraint and risks associated with restraint in the long-term care plan. A documented three-monthly review of restraint has been conducted.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	There is a policy in place for the use of covert medications. Not all medications given covertly were according to the policy.	Two of the ten medication charts included the direction to crush medication. This was to ensure the resident took the medication and the medications were given covertly. There was no documentation to evidence that the family/EPOA had been informed of this. There was no GP assessment and the long-term care plan did not include the need for covert medications.	<p>Ensure that the use of covert medications is according to policy.</p> <p>60 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal</p>	PA Low	The kitchen was observed to be clean and regular audits undertaken to ensure that food standards are maintained.	Aspects of the kitchen environment are worn including: a rusty food mixer stand; a rusty tin opener attached to the preparation work top; chipped and peeling formica on the food prep work	Ensure that the work area is maintained

<p>comply with current legislation, and guidelines.</p>		<p>There is a verified food control plan expiring September 2019. Aspects of the kitchen environment needed repair.</p>	<p>top; and shelves.</p>	<p>in good repair. 180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.