

Logan Samuel Limited - Anne Maree Gardens

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:

Legal entity:	Logan Samuel Limited
Premises audited:	Anne Maree Gardens
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 18 June 2019 End date: 18 June 2019
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:	73



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

Anne Maree Gardens is managed by a facility manager who reports directly to the general manager. Other members of the management team are the clinical leader who is a registered nurse, and a full-time administrator. The service is one of two facilities privately owned by the same owner/director. The service has a total of 76 beds for rest home and hospital level care residents including younger persons and for psychogeriatric care.

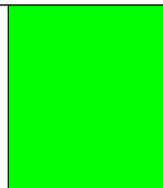
This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board and the Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff, a contracted allied health physiotherapist, the visiting psychiatrist, a member of the district health board's mental health services for older people team, the owner/director and a general practitioner.

This audit has resulted in two continuous improvement ratings, one in activities and one related to complaints management. One area for improvement relates to registered nurse staffing in the nine bed psychogeriatric unit.

There were no areas requiring improvement to be followed up from the previous audit.

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.



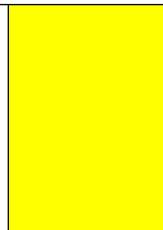
Standards applicable to this service fully attained.

Open communication between staff, residents and a family member 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. Complaints information is shared with residents and staff throughout the service and used to improve services as appropriate.

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.

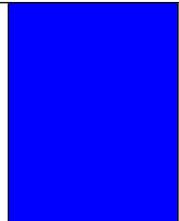
Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the owner/director is regular and effective. An experienced and suitably qualified person manages the facility.

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 current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. 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.		All standards applicable to this service fully attained with some standards exceeded.
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Registered nurses assess all residents on admission. Initial care plans guide service delivery during the first three weeks after admission. The interRAI assessment process is used to identify resident's needs and these are completed within the required timeframes.

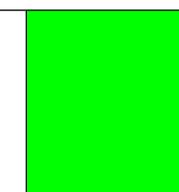
Care plans are individualised and based on an integrated range of clinical information. Short-term care plans are in place to manage any issues or problems. Residents' records reviewed demonstrated their needs, goals and outcomes are identified and reviewed at regular intervals. Interviews confirmed residents and families are informed and involved in care planning and evaluation of care. Handovers between shifts guide continuity of care and service provision.

The activities programme is implemented to cover all residents in each area of service. The individual activities plans are reviewed six monthly by the diversional therapists. The programme provides residents with a variety of individual and group activities. The service uses its facility van for outings in the community.

Medicine management is implemented according to policies and procedures in alignment with legislative requirements. An electronic medication system is used and records were reviewed. Medicines management competencies for staff who administer medicines were current. The clinical leader has prescribing rights under the general practitioner's mentorship and instructions.

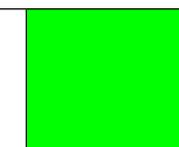
The food service meets the nutritional and other specific needs of the residents. Kitchen staff have completed relevant food safety training. The kitchen was clean and meets food safety standards and has a current food control plan. Residents and family confirmed satisfaction with the meals.

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.
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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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Two restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound

knowledge and understanding of the restraint and enabler processes. The environmental restraint, owing to the exterior gates being on a key-pad lock, is identified and managed as per policy.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection prevention and control surveillance is undertaken, analysed and trended. Surveillance records showed evidence of follow-up of infection when required. The infection surveillance programme is reviewed annually. Staff interviewed demonstrated current knowledge and practice in relation to the implementation of infection prevention and 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	1	14	0	1	0	0	0
Criteria	2	36	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 reviewed showed that 51 complaints, concerns or issues have been received in 2019 and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed all required follow up and improvements have been made where possible. The facility manager, clinical leader and administrator are responsible for complaints management and follow up. This is undertaken using a quality process to ensure all residents, family and staff are kept informed of outcomes. The follow up process is very clearly documented in detail to show who undertook the required actions, the improvements made to resolve the issue and evaluation that actions put in place have gained a positive outcome prior to the closing off of any issue. All staff, residents and family interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication Service providers</p>	FA	<p>Residents and family members stated they are kept well informed about any changes to their/relative's status and were advised in a timely manner about any incidents or accidents and outcomes of regular or urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure which</p>

<p>communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>is supported by policies and procedures that meet requirement of the Code. There is a communication book in the main staff office for recording up and coming outpatient appointments for residents. Staff reported at interview that verbal handovers are provided between shifts and this was observed in the afternoon on the day of audit.</p> <p>Staff know how to access interpreter services although reported this was rarely required as staff and family/whanau are available to translate when required.</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>The strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of quarterly reports to the owner/director showed adequate information to monitor performance is reported including health and safety, occupancy, staff appraisals, interRAI assessments, quality data results, laundry services, marketing, policy development, emerging risks and issues. The actions taken to achieve each set goal are also measured in the report. The facility manager also reports verbally, on a weekly basis, to the general manager, who works across both facilities owned by the same owner/director. The general manager is on call at all times should the facility manager have any concerns.</p> <p>The day to day service is managed by a facility manager who holds relevant qualifications and has been in the role for nine years. The facility manager is supported by a clinical leader who is a registered nurse who has worked at the facility since 2009 and been in the current position since 2014, and a full time administrator who has worked at the facility for over 10 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The members of the management team confirmed their knowledge of the sector, regulatory and reporting requirements and maintains currency through appropriate ongoing education related to their role. For example, the clinical leader has completed post-graduate education and holds a Masters of Nursing degree and has nurse prescribing rights in aged care. The facility manager holds a diploma in business management and attends age care management seminars and training days. The facility manager also organises and chairs regular meeting of age care service managers from West Auckland where quality issues are discussed and education is provided. The administrator attends ongoing education including on-site and e-learning education covering a wide variety of topics.</p> <p>The service holds contracts with Auckland District Health Board (ADHB) and the Ministry of Health (MoH) for under 65 year olds, respite, medical conditions, rest home level care, psychogeriatric care, chronic health conditions and individualised residential care for residents who have mental health input.</p> <p>Contracts held are:</p> <p>Long Term Services for Chronic Health Conditions (ADHB) - two residents were receiving services under this contract.</p> <p>Individual Client Residential Care over 65 years (ADHB) – one resident was receiving services under this contract.</p>

		<p>Individual Residential Support under 65 years (ADHB) – two residents were receiving services under this contract.</p> <p>Aged Residential Hospital Specialist Services (psychogeriatric only) (ADHB) – six residents were receiving services under this contract.</p> <p>Long Term Support Chronic Health Conditions Specialised Psychogeriatric (ADHB) – two residents were receiving services under this contract.</p> <p>Residential Non-Aged (MOH) - two residents were receiving services under this contract.</p> <p>Age Related Residential Care (ADHB) – 58 residents were receiving services under this contract being 25 rest home level care and 32 hospital level 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 principles.</p>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, resident and family satisfaction surveys undertaken for various topics throughout the year, such as food surveys (May 2019), activities (May 2019), resident and family satisfaction survey (June 2019), monitoring of outcomes, clinical incidents including infections and wounds, skin tears, bruising, behaviour, and pressure injuries.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the integrated monthly meetings, staff meetings and quarterly meetings with the owner/director. Statistics are discussed weekly with the general manager. Staff reported their involvement in quality and risk management activities through audit activities and implementation of corrective actions. Relevant corrective actions are developed and implemented to address any shortfalls. The results from satisfaction surveys showed that all required actions have been documented and addressed by the service as required.</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>Members of the management team described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	FA	<p>Staff document adverse and near miss events on an electronic accident/incident form. A sample of incidents forms reviewed showed these were completed, incidents were investigated, action plans developed and actions followed-up in a timely manner by the clinical leader. Adverse event data is collated, analysed and reported to the</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>management team, owner/director and staff.</p> <p>The facility manager and clinical leader described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, or district health board since the previous audit. There have been no police investigations, coroner's inquests, issues based audits and any other notifications, such as to public health services, since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</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 show documentation of completed orientation and a performance review after one year and then annually. A verbal review of staff performance is undertaken after three months of employment, or sooner if there are any concerns noted.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Three staff members are approved internal assessor for the programme. Staff working in the psychogeriatric area all hold required education to meet contractual requirements. There are three trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals related to interRAI.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	<p>PA Low</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 afterhours 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. During interview, staff stated that sometimes there were more rostered staff than required. Residents and family interviewed supported this. Staffing levels meet the interRAI acuity level report findings. Observations and review of four weeks rosters confirmed adequate staff cover has been provided, with staff replaced in any</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>unplanned absence. All staff hold current first aid certificates. There is 24 hour/seven days a week RN coverage in the facility. One registered nurse is nominated to oversee the nine bed psychogeriatric unit between the hours of 7am to 11pm. The nurse does not always remain in the unit. However, there is only one registered nurse from the hours of 11pm to 7am to cover the whole facility.</p> <p>Activity staff cover seven days a week. Dedicated kitchen staff and cooks work seven days a week to cover all meal-times. Laundry is sent off site but there is a dedicated laundry staff member who ensures laundry is put away when returned who works seven days a week for 7.5 hours per day. Dedicated cleaning staff work seven days a week.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management system is documented, implemented accordingly and complies with legislation, protocols and guidelines.</p> <p>Anne Maree Gardens uses pharmacy pre-packaged medicine that is checked by two RNs on delivery. An electronic medication system is used. Weekly checks and six monthly controlled drugs stocktakes are conducted and confirmed that stock levels are correct. The clinical leader is able to prescribe under the supervision of the GP. The clinical leader interviewed is the first Nursing Council of New Zealand approved RN prescriber working in a gerontology care setting that is able to prescribe who is not a nurse practitioner.</p> <p>The medication fridge temperatures are monitored. A system is in place for returning expired or unwanted medications to the contracted pharmacy. All medications are stored appropriately. Review of the medication fridge confirmed that the service does not store or hold vaccines and interviews with the clinical leader and a registered nurse confirmed they do not hold any vaccines on the premises.</p> <p>The staff administering medication complied with the medicine administration policies and procedures. A safe process was observed. Current medication competencies were evident in staff records sampled where applicable.</p> <p>There were no residents self-administering medicines at the time of audit. A process is in place to ensure ongoing competency of the resident to self-administer if required and if authorised by the GP.</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</p>	<p>FA</p>	<p>All meals are prepared on site by the cook. The cook interviewed previously worked in the weekend and was available to cover the main cook. The main cook recently resigned and the weekend cook now works full time. The seasonal menu was reviewed by a consultant dietitian on the 14 November 2018. The food control plan is due to expire 2 July 2109. All kitchen staff have current food management certificates.</p> <p>Residents' dietary profiles are developed on admission as part of the admission process by the RN. Any identified dietary requirements and preferences are recorded. The dietary profiles are communicated to kitchen staff. Kitchen staff are updated if a resident's dietary needs change and when dietary profiles are reviewed six monthly. Diets are modified as required and the kitchen staff interviewed confirmed awareness of the dietary needs of residents. These</p>

<p>service is a component of service delivery.</p>		<p>are also clearly documented on the whiteboard in the kitchen for quick reference as needed. Supplements are provided to residents with identified weight loss problems.</p> <p>All food procurement, production, preparation, storage, delivery and disposal sighted at the time of the audit meet the requirements of the standard. The cook is responsible for ordering the food to meet the requirements of the menu plans. Food is stored appropriately in fridges and freezers which are daily monitored and dry food supplies are stored in the pantry.</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>The residents' care plans are completed by the RN and based on assessed needs, desired outcomes and goals of the residents. Care planning includes specific interventions for both long-term and acute problems and are consistently recorded to meet the goals set.</p> <p>The GP documentation and records were current. Interviews with residents and family confirmed that care and treatment meets the residents' needs. Staff interviewed confirmed they are familiar with the needs of the residents. There is a stable core of staff. Family communication is recorded in the individual progress records. The nursing progress notes and observation records are maintained.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>CI</p>	<p>The activities programme/calendar is developed and implemented. There are two diversional therapists (DTs) and three activities coordinators. Two sessions are planned for each individual day of the week. The DTs plan a variety and range of activities both group and individual due to the nature of the services provided. Programmes are displayed in the service areas and in each resident's individual room. On visual inspection, photo-boards provide evidence of all social events and outings of interest to the residents. The service hires a van for activities in the community and links with other like services and community groups on a regular basis. An additional activity has been implemented in the afternoon which has resulted in positive outcomes for the residents.</p> <p>There are five YPD residents (three rest home and two hospital level care residents). Activities, such as Friday night dinners and movies, are planned regularly for the YPD residents. Each YPD resident has their own individualised activities plan.</p> <p>From assessments on admission the DTs establish with the resident and/or family interests that are meaningful to each individual resident. One on one and group activities are documented on the individual activities plans reviewed. Each resident's plan is reviewed six monthly at the MDT meeting, interRAI re-assessments and care plan reviews. The residents and family interviewed reported satisfaction with the activities programme.</p>
<p>Standard 1.3.8:</p>	<p>FA</p>	<p>The long-term care plans and the short-term care plans are evaluated in a timely manner after the interRAI re-</p>

<p>Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>assessments are completed. The evaluations include the degree of achievement towards meeting desired goals and outcomes. Residents' responses to their treatment are documented. Changes in the interventions are initiated when the desired goals/outcomes are not achieved. The clinical leader interviewed has a schedule which reflects when each individual resident's interRAI assessment is due, when the care plan is due to be reviewed and when the multidisciplinary meetings (MDT) are due.</p> <p>Short-term care plans are developed for acute problems or issues when needed. These record goals and the required interventions for the identified short-term problems. The short-term care plans reviewed were signed, dated and closed out when the short-term problem had been resolved.</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>	FA	<p>A current building warrant of fitness (expiry date 01 June 2020) is publicly displayed.</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 infection prevention and control programme is site specific and reviewed annually. A senior health care assistant with an interest in infection prevention and control regularly completes a 'physical round' of the facility and all service areas and reports any infection control issues directly to the clinical leader who follows these up. The clinical leader is the infection control coordinator for this service.</p> <p>The surveillance policy identifies the requirements around the surveillance of infections. RNs report on-line any infections or antibiotics in use to the clinical leader. The clinical leader collates monthly infections, analyses data, compares the incidence of infections to the previous months' results, the reason for the increase or decrease and the action advised. Any recommendations or outcomes are documented and discussed at the monthly staff meetings. Graphs sighted demonstrated frequency of infections. Residents records evidenced that those residents diagnosed with an infection had short-term care plans in place. The clinical leader reports to the GP in a timely manner.</p> <p>Interviews with care staff verified they are made aware of any infections through feedback from the RNs, meeting minutes, verbal handovers, short-term care plans and progress notes. This was confirmed during attendance at the handover and review of the residents' records. The clinical leader confirmed that the last infection outbreak was 18 months ago and the appropriate agencies were notified and all protocol was followed as per the infection prevention</p>

		and control manual. Records were maintained throughout the outbreak.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 restraint coordinator (the clinical leader) 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 their role and responsibilities.</p> <p>On the day of audit, two residents were using restraints. No residents were using enablers. Policy identifies that enablers are the least restrictive and used voluntarily at the resident's request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>The gate to the car park is on a key pad lock. This is documented as environmental restraint in policy to meet standard requirements. This was confirmed during interviews and residents were observed leaving the grounds when they wished.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>Rosters identify that staffing numbers allow safe delivery of 24 hours, seven days a week care for residents. Staffing levels for the aged care unit meet interRAI acuity levels. During staff interviews they confirmed there are adequate numbers of staff available on all shifts to ensure safe services are provided to all residents. Staff replacements are clearly identified on the rosters sighted. The nine bed psychogeriatric unit has a nominated register nurse on morning and afternoon shift but they do not always remain in the unit. There are two dementia trained health care assistants rostered in the psychogeriatric unit from 11pm to 7am, however there is only one registered nurse on duty from 11pm to 7am at the facility who covers both the psychogeriatric unit and the care unit. No incidents have been documented during the hours of 11pm to 7am.</p>	<p>The psychogeriatric unit does not have a dedicated registered nurse to cover all shifts. The contact required that a there is a registered nurse in the psychogeriatric unit across all shifts.</p>	<p>Ensure that contractual requirements are met related to having a dedicated registered nurse rostered in the psychogeriatric across all shifts.</p> <p>30 days</p>

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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	CI	<p>The service has an easily accessed, responsive and fair complaints, concerns and issues process to ensure all resident and family concerns are captured and responded to promptly. The service identified a need to capture/include all issues, concerns and complaints no matter how minor, in the process. They have implemented a quality improvement process which ensures the outcomes are evaluated and that the implementation of corrective actions are embedded into everyday practice. The service has complaints forms clearly identified at the entrance to the service, staff document all verbalised concerns on complaints forms. The monthly residents’ meetings are used to identify any concerns no matter how minor. There is an advocacy group which is made up of representatives from under 65-year olds, long term care, hospital and rest home level care residents. They meet one or two days prior to the residents’ meetings. They discuss minor concerns raised by residents, such as staff speaking too loud during meal times, and items are placed on the residents’ meeting agenda. They are then dealt with via the complaints process. The</p>	<p>The service actions all complaints, concerns and issues using a robust process which ensures all actions are implemented and evaluated in a transparent manner to include residents, family and staff as appropriate. The documentation related to complaints, concerns and issues is very detailed showing what actions were implemented, how they had been embedded into everyday practice, evaluation of outcomes and how the actions have improved service delivery. Residents and family members confirmed that all issues raised are dealt with in a prompt, professional manner at all times. Documentation identifies that resident input into seeking and monitoring positive outcomes to complaints, concerns and issues is valued by the service. The service evaluated the complaints management process and as all complaints, concerns and issues are now</p>

		<p>advocacy group review outcomes of previous concerns or complaints which have all been resolved to their satisfaction.</p> <p>Complaints or issues are also documented at the time they are received; this information is written in the staff communication book and discussed at each staff shift handover. To ensure all residents are satisfied with the complaint or issues raised follow up, an evaluation form is written and outcomes are discussed at the monthly residents' meetings. The evaluation form identifies the implemented actions undertaken to resolve each complaint and the residents decide if the issue has been resolved to their satisfaction or if it remains unresolved. The residents' meeting minutes for 2019 identify all issues had been resolved to the residents' satisfaction. For example, some of the residents complained that their birthday cakes were not freshly made but sometimes had been frozen. This was discussed with the kitchen staff who agreed all birthday cakes would be freshly made for each occasion. The residents were very happy with this outcome.</p> <p>Family complaints are responded to in writing to meet policy requirements. For example, one family member made a complaint about poor communication related to picking up their relative. The apology letter to the family identified actions taken, the reason the incident occurred and the assurance of the implementation of the actions taken to prevent this occurring again. The issue was resolved to the family member's satisfaction.</p> <p>The residents and family member interviewed on the day of audit agreed they are kept very well informed about any concerns or issues that arise and that they feel included throughout the complaints process which allows them to evaluate the success of implemented actions. Documentation sighted shows that all issues are recorded through to a resolution. Staff confirmed they are also informed of all outcomes at their monthly meetings.</p>	<p>captured and recorded regardless of how small the issue is this has improved service delivery to ensure resident satisfaction.</p>
<p>Criterion 1.3.7.1 Activities are planned and</p>	<p>CI</p>	<p>All residents have an individual activities plan in place. The plans are developed to ensure the skills, resources and interests of each individual resident is maximised. Many residents at Anne</p>	<p>The achievement of quality improvement projects incorporated into the activities afternoon programme and the implementation of increased</p>

<p>provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>Maree Gardens have high needs and challenging behavioural issues to be considered. A project was instigated due to a high number of falls, altercations, aggressive incidents and residents being agitated by the gate closure, 'sundowners' and not being able to go outside on rainy days. An extended time frame for music therapy using musical videos and other musical activities in the afternoon, weekends and on rainy days was approved by management and was implemented. Residents reacted well to this music activity and this was observed in progress at the time of the audit. Resulting evidence demonstrated residents being more settled, calm, less aggressive and relaxed. Some residents were observed interacting with other residents and those that wandered were less likely to leave the facility in the afternoons and there has been a decrease in the number of resident altercations, falls, wandering and aggressive behaviour at that time of day.</p>	<p>activities for YPD residents, high needs residents and those who presented with high levels of behavioural challenges and aggression is rated as beyond the expected full attainment. The DT interviewed explained that since the music project was introduced a variety of residents spend time involved in this daily activity together (e.g., independent/hospital/psychogeriatric/younger people, and people of different cultures and abilities). There is a documented review process which includes the analysis and reporting of findings, resident, family and staff feedback which has been positive. A music activity satisfaction survey was also completed. The measured outcomes are many but above all the residents really enjoy and look forward to this additional daily activity and incidents have decreased.</p>
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End of the report.