

Clare House Care Limited - Clare House

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:	Clare House Care Limited	
Premises audited:	Clare House	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 20 October 2020	End date: 21 October 2020
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:	68	

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

Clare House is an aged care facility that provides rest home, medical/geriatric hospital care and dementia care for up to 69 residents. The service is operated by a private company, Clare House Care Limited, and managed by a general manager and a facility clinical manager. Visiting professionals described the care provided as professional and residents and families expressed high levels of satisfaction with the care.

This 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, managers, staff, a contracted allied health provider and a general practitioner.

This audit has resulted in a continuous improvement rating in relation to two clinical care projects and identified three areas requiring improvement relating to implementation of aspects of the quality and risk management system, human resources documentation and activity plans for people in the dementia unit. Improvements have been made to the evaluation of quality data and the storage of oxygen, addressing those areas requiring improvement at the previous certification 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.
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Staff promote open communication with residents and family members, especially following medical examinations or an adverse event. There is access to interpreter services if required.

Residents and family members are informed about how to make a complaint on entry to the service. A complaints register is maintained and demonstrated complaints are 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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A business plan, associated documentation and a separate quality and risk management plan include the scope, direction, goals, values and mission statement of the company. Monthly monitoring reports about the services are being provided to the governing body in an effective manner. 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. An internal audit system is being maintained. Adverse events are documented with corrective actions identified.

Actual and potential risks, including health and safety risks, are identified. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff are based on current good practice. A systematic approach to identify and deliver ongoing training 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.		Some standards applicable to this service partially attained and of low risk.
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The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with 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 on public display. No modifications have been made to the building since the last audit.

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. At the time of audit, seven residents were voluntarily using enablers, as per their request. Ten restraints were in use and the restraint register provided information on the approval, review and evaluation of their use. Monitoring processes are in place. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	14	0	3	0	0	0
Criteria	1	35	0	3	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 and concerns 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 electronic complaints register reviewed showed that ten complaints have been received since the previous audit and that actions taken, through to an agreed resolution, are documented within the electronic system and completed within the timeframes. Two complaints remain open awaiting confirmation of the resolution with family members. The general manager, who is responsible for complaint management, noted that all of the complaints had originated as an expressed of concern only. Action plans showed any required follow up and improvements have been made where possible. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit. A complaint that had been lodged with the Health and Disability Commissioner (HDC) around the time of the previous audit was withdrawn by the complainant and correspondence (November 2018) from the HDC noted the complaint was 'withdrawn' and noted that no assessment had been undertaken by their office.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>Residents and family members stated they are consistently advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was evident in family communication records in residents' files reviewed and in the incident recording system. Staff understood the principles of open</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>disclosure, which is supported by policies and procedures that meet the requirements of the Code, including for incidents and complaints.</p> <p>Staff knew how to access interpreter services through the Southern District Health Board and were aware of the policy and procedure in the policy manual for other options. They informed this has not been required for as far back as those interviewed were aware of. Families are encouraged to provide useful information for assisting their relative with communication if a person has difficulties in this area, especially for those with dementia. A person who has English as a second language but does understand English will often use family to assist with communication in their own language. During the Covid-19 lockdown, electronic systems such as Facebook, Messenger and Video calls were used to support communication processes.</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>A 2020 business plan outlines the purpose, scope, direction and goals of the organisation. The documents described annual and longer-term objectives and included a strengths, weaknesses, opportunities and threats overview of the facility and services provided. Associated operational plans were provided by one of the directors. The general manager provides the directors with weekly reports, which are cumulative to monthly reports. Samples of these dating back to 27 June 2020 were viewed. These showed adequate information to monitor performance is being reported and included occupancy, meetings, facilities, defects, maintenance, staffing, financial, marketing, health and safety and other, including pandemic planning. In addition, the general manager has a 'zoom' meeting with the one of the directors each week and the two directors visit the facility for a directors' meeting every quarter.</p> <p>The service is managed by a general manager who holds relevant qualifications and has been in the role for approximately two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. As a previously trained health professional and over 42 years of service in the health sector, much of which has been in DHB management roles, the general manager confirmed knowledge of the sector, regulatory and reporting requirements. Currency of knowledge is maintained through attending meetings with managers from other local aged care facilities and with the DHB portfolio manager, undertaking additional post graduate education, attending aged care related conferences and maintaining links with a palliative care group and a dementia stakeholder group.</p> <p>The service holds contracts with the Southern District Health Board for rest home, medical/geriatric hospital care, dementia care and respite care under the Aged Related Residential Care (ARRC) agreement, as well as for chronic care and palliative care. Sixty-seven residents were receiving services under the ARRC agreement with 20 rest home, 26 hospital and 21 dementia care, one of whom is in residence for respite care. An additional person in an apartment under an occupation right agreement receives subsidised rest home care.</p>
<p>Standard 1.2.3: Quality And Risk</p>	<p>PA Low</p>	<p>Since the last audit, the service provider has contracted with a new quality consultant and has commenced implementing a different quality assurance and risk management system. This is clearly documented, reflected the</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>principles of continuous quality improvement and included management of incidents and complaints, internal and external audit activities, monitoring of outcomes and oversight and review of clinical incidents including infections and restraint use.</p> <p>Alongside this quality system are policies and procedures that 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>With implementation of the new quality and risk systems, as well as the interruption of Covid-19, some aspects of quality assurance processes have not been maintained and have resulted in a corrective action being raised. A residents' food survey has been undertaken but has yet to be analysed. There was good evidence that quality improvement data for incidents, infections and complaints is being collected, analysed and evaluated to identify trends leading to improvements, and these processes address a corrective action raised at the previous audit. Good examples of these have been further described in standard 1.3.3. Internal audits are being completed according to the annual schedule. Relevant corrective actions are developed to address any shortfalls within the quality system.</p> <p>The general manager is the health and safety officer, has undertaken relevant training and is familiar with the Health and Safety at Work Act (2015). Processes in place for the identification, monitoring, review and reporting of risks and development of mitigation strategies were described.</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 and this is scanned into the electronic incident reporting log. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, and action plans developed. Not all records showed actions had been followed-up in a timely manner and this has been raised for correction under criterion 1.2.3.7. A log of adverse events is being maintained. Adverse event data is collated, analysed and reported using the quality consultant's electronic system, which is enabling benchmarking with other similar facilities to occur.</p> <p>The general manager described essential notification reporting requirements. They advised there have been five notifications of significant events made to the Ministry of Health since the previous audit, including for a pressure injury, change of clinical manager, and three people having wandered from the facility with staff not being aware. Overall, the facility clinical manager follows up any clinical issues of concern and preventive measures and the general manager follows through the organisational and environmental issues.</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>PA Low</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process reportedly includes a formal application, an initial interview, referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. Annual practising certificates for all health professionals who have contact with the residents were viewed and were current. A corrective action has been raised in relation to a lack of evidence that the service provider's human resource policies and procedures are being consistently implemented.</p> <p>Staff orientation includes all necessary components relevant to the role and requires completion of a checklist and designated competencies. New staff are buddied with a longer-term staff person for three days. Staff reported that the orientation process prepares new staff well for their role and ongoing support is provided within the team. Staff records reviewed showed documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, according to the list in the policy manual provided by the quality consultant. All staff are required to complete mandatory requirements at half days provided every six months, with the latest being the week prior to the audit. 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, or they are currently undertaking other health related training such as registered or enrolled nursing, or midwifery. A care assistant has gained competency and is now the internal assessor for the programme. All care assistants (nine) working in the dementia care unit, other than one new person, one doing her enrolled training and one with it underway, have completed the required education. The team leader and registered nurse in the area are highly experienced.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training; however, not all annual performance appraisals are being completed within the required timeframe and this has been raised within the corrective action for this standard.</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>An annual leave and rostering policy and procedure within the organisation's policies and procedure details the process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The general manager and facility clinical care manager described examples of how staffing levels had been adjusted to meet the changing needs of residents. This was especially evident through implementation of a quality improvement project, which to date has seen a change in the rosters. The project involved staff consultation and union consultation. It commenced with an 'above the line and below the line' analysis of what ideal staff relationships would look like and what impact these have on resident care. At the time of audit, the service provider was one week into the changes made to date. Ongoing review is to occur, and evaluation is planned.</p> <p>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 and they have</p>

		<p>appreciated the consultation process to address what they had perceived as staffing inequities. Residents and family members interviewed confirmed there are adequate staff and that managers are always available to respond when the care staff are busy. Observations and review of five weeks of rosters confirmed adequate staff cover has been provided, with staff replaced in most unplanned absences. In addition to full time staff picking up an extra shift, there is a casual pool of care assistants to call on. When staff are not replaced, a care assistant will work a longer shift and one from the next shift commences their shift earlier. The facility clinical manager relieves when a registered nurse is absent. As all registered nurses have a current first aid certificate, and there is 24/7 registered nurse cover in the hospital, there is always at least one staff member on duty meeting this requirement. Registered nurses undertake medicine administration whenever possible; otherwise a senior care assistant will undertake this role according to a list in the handover folder. A separate roster for support staff, which includes the activities coordinator, is developed by the general manager.</p> <p>One person in a village apartment occupied under an occupation right agreement receives rest home care. A dedicated village care assistant attends to this person Monday to Friday during morning shift hours. Enrolled nurses include them in their resident allocation on other shifts.</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 policy is 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 each stage of medicine management. All staff who administer medicines are competent to perform the function they manage with competencies being renewed on an annual basis.</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 on request.</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 and six-monthly 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 no residents self-administering medications at the time of audit across all three service streams.</p>

		<p>Appropriate processes are in place to ensure this is managed in a safe manner should it be required.</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>	FA	<p>The food service is provided on site by three cooks and a kitchen team and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (16 November 2019). 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 Invercargill City Council and is current until 31 August 2021. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training as sighted in files.</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. All dietary profiles are updated three monthly and the kitchen receives a copy. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews and residents' meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner.</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>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP and physiotherapist interviewed, verified that input is sought in a timely manner, that orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available including air mattresses, recliner chairs used to change position of immobile residents, and appropriate dressings, suited to the level of care provided and in accordance with the residents' needs.</p>
Standard 1.3.7:	PA Low	<p>The activities programme at Clare House is provided by three activities coordinators (one who is near finishing her</p>

<p>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>qualification). Each one working in one of the three service streams.</p> <p>On admission, the resident and family/whānau complete a social history to ascertain residents' needs, interests, abilities and social requirements. Activities assessments and care plans are then completed to help formulate an activities programme that is meaningful to the residents and appropriate to their needs and preferences. The residents' activity needs are evaluated twice a month documenting engagement and participation and as part of the formal six-monthly care plan review in line with interRAI reassessments.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities such as newspaper reading, quiz time, exercises/Tai Chi, and crafts. Clare House has two vans which are used for outings and trips to the shops and library. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interesting and varied.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there including 'fiddle boxes', nuts and bolts for sorting and taking residents for walks. The requirement to have individualised care plans in regard to behaviour management and activities that cover the 24-hour period is not being met resulting in a corrective action.</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>Resident 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. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for wound management. 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. Care staff stated that they have discussions at handover regarding changes in effectiveness of interventions which are reflected in the care plan evaluations.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	<p>FA</p>	<p>A current building warrant of fitness that has an expiry date of 13 December 2020 was publicly displayed. There have been no structural modifications to the facility since the last audit. Changes in regulations related to gas bottle placement has seen a requirement to update the gas safety certificate and for key staff to undertake specific relevant training. The associated requirements have been met.</p>

facilities that are fit for their purpose.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A corrective action regarding oxygen bottle storage was raised at the previous audit. Oxygen bottle storage was checked, and all were secured to the wall as required. Appropriate signage on the door of the storage area and above the oxygen bottles was in place. Tear off sections of the labels on each cylinder demonstrated the status of available oxygen in each bottle. The maintenance person provided records confirming these aspects of oxygen storage are being checked weekly.</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 infections of the urinary tract (with and without a catheter), upper and lower respiratory tract, eyes, skin and tissue, influenza, gastro-intestinal and 'other'. The infection prevention and control nurse reviews all reported infections, and these are documented directly into the electronic recording system. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff at shift handovers. Graphs and monthly summaries that include possible contributing factors, preventive or corrective measures and risk factors are displayed in the staff room and the training room. The graphs produced identify trends for the current year, as well as comparisons against previous years and the industry average. Infection reports are provided to the quality and risk management meetings.</p> <p>Evidence of additional information, updates and education for staff during and since the Covid-19 pandemic lockdown was provided. Relevant personal protective equipment is available should this be required.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</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 was absent during the audit; however, the facility clinical manager described how the restraint coordinator supports staff and provides oversight for enabler and restraint management in the facility. Details on the role and responsibilities of the restraint coordinator are described within the policy documentation.</p> <p>On the day of audit, the restraint and enabler register listed ten residents as using a restraint and seven residents as using an enabler, all of which were bedrails. A similar process is followed for the use of enablers as is used for</p>

minimised.		restraints, excepting the use of an enabler is voluntary, and according to each resident's request. During interview, staff confirmed their knowledge about the differences between an enabler and a restraint and the monitoring requirements for restraint use. An internal audit on restraint management was completed in September 2020, the month prior to the audit visit.
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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 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	<p>The organisation’s quality assurance and risk management plan described processes against which to measure its objectives. These are not being implemented, reviewed and reported in a consistent manner. For example, there was limited evidence to demonstrate corrective actions developed for quality improvement purposes are always implemented within a timely manner. Only small numbers of staff are attending quality and risk management meetings and staff reported that, other than receiving the graphs about incidents in the staff room, they are no longer involved in aspects of quality and risk management unless they attend these meetings. Residents, next of kin and staff surveys were not undertaken in 2019 and regular reviews of health and safety processes have lapsed.</p>	<p>There are aspects of the quality and risk system that are not consistent with those described within the quality and risk management plan. These include:</p> <ul style="list-style-type: none"> - Corrective actions identified are not all being closed out in a timely manner - Service providers are not all receiving communication / updates about various aspects of 	<p>Processes for the purpose of maintaining the quality assurance and risk management system and to measure achievement against the quality and risk management plan are implemented. These include the follow-up of corrective actions, the re-institution of health and safety reviews and of resident, relative and staff surveys as well as, staff involvement and improved attendances at relevant meetings.</p> <p>180 days</p>

			<p>the quality and risk management system</p> <ul style="list-style-type: none"> - Health and safety meetings and follow-up have become infrequent - Attendance at quality and risk meetings is minimal - Resident, next of kin and staff surveys have not been undertaken; therefore related quality improvement opportunities have not been identified. 	
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	<p>A sample of staff records reviewed confirmed the organisation's policies are mostly being implemented. However, changes in administrative processes have meant that records are not being maintained in a manner that confirms police checks are being completed and nor were signed position descriptions in all of the files. The manager informed that efforts to catch up on overdue annual performance appraisals for all staff have been made; however, records sighted confirmed that a number of these are still outstanding.</p>	<p>There is a lack of evidence that human resource processes are being implemented according to the service provider policies and procedures:</p> <ul style="list-style-type: none"> - Records confirming police checks are being undertaken for new staff are no longer available - Signed position descriptions were not 	<p>Human resources processes are implemented according to organisational policies and procedures and legislative requirements to ensure the needs of residents are safely met.</p> <p>180 days</p>

			<p>found in five of the sample of eight staff files viewed</p> <p>- Performance appraisals are not being consistently completed on an annual basis.</p>	
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	<p>In the Aged Related Residential Cares Services Agreement (ARRC), dementia units are required to have a description in the resident's file of how challenging behaviour is best managed, and the activities that meet the resident's needs in relation to individual diversional, motivational and recreational therapy during the 24 hour period reflecting resident's former routines and activities that are still familiar to the resident (E4.3iii and iv). These 24-hour plans were not found in residents' records reviewed. The registered nurse confirmed that care and behaviours were managed well but they were not using the 24-hour template that is provided.</p>	<p>In the dementia unit, some details of activities and behaviour management were observed in the activities care plan; however, none of the residents' files evidenced a plan describing how behaviour is best managed or activities best suited to the needs of the resident over the 24-hour period.</p>	<p>As required in clause E4.3iii and iv of the ARRC agreement, each resident in the dementia unit will have a plan describing behaviour management and individualised activities reflecting former routines covering the 24-hour period.</p> <p>90 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 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where</p>	CI	<p>Following a corrective raised in the previous certification audit in relation to the need to collect, analyse and evaluate quality improvement data, the service provider has responded by using the information for specific quality improvement initiatives. At the time of audit, several of these had not yet been evaluated; however, two specific examples can be used to acknowledge continuous improvement.</p> <p>Adverse event data showed a high number of non-fall related skin tears. Data was analysed on a monthly basis. Research was completed about skin moisturising, the GP charted moisturiser, care plans were altered to reflect this intervention and care staff implemented this. In conjunction with this intervention, the physiotherapist held manual handling training sessions and worked with care staff during her visits to ensure safe transfer was taking place. Monthly data was collated and over the period November 2018 – December 2019 a decrease in non-fall related skin tears of 51% was achieved, reducing pain and risk of infection to the resident.</p> <p>A second initiative to reduce falls was in place during the same time frame. Incident/accident reports were analysed to identify and address trends using an electronic quality system. Staff education in small groups with the physiotherapist was held in addition to annual training. Policies</p>	<p>The analysis of data, research and implementation of education using a team approach is now able to be used to improve service delivery to the residents resulting in less harm, pain, and time and product involved in wound care, and earlier intervention in assessing the level of care required by residents.</p>

appropriate.		and procedures were updated to reflect current best practice. Sensor mats, pre-empting toileting, and ongoing physiotherapist input were implemented by staff as part of the initiative. The use of collated data did not show a decrease in the number of falls but instead gave staff a greater understanding of why falls were occurring, specifically the relationship of residents needing to progress into a higher level of care as evidenced by decline in mobility and insight into their safety needs. As a result, when the summary reports showed an increase in an individual's fall rate staff were able to look at all aspects of care and use it as an early warning tool to arrange reassessment for a higher level of care. This is now being used pro-actively when requesting reassessment of a resident's care acuity.	
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End of the report.