

B.J.M.H.Enterprises Limited - Killarney Rest Home

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 BSI Group New Zealand Ltd, 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:	B.J.M.H.Enterprises Limited	
Premises audited:	Killarney Rest Home	
Services audited:	Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 14 October 2020	End date: 15 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:	21	

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

General overview of the audit

Killarney Rest Home provides rest home and dementia level care for up to 22 residents. On the day of audit there were 21 residents.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, relatives, management, staff, and a general practitioner.

The service is managed by the director/manager, an assistant manager, and a clinical manager. The residents and relatives interviewed spoke positively about the care and support provided.

This audit identified a corrective action around medication management.

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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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There is an annual business plan and a risk management plan in place. The plans define the scope, direction and objectives of the service and the monitoring and reporting processes.

There is an established quality and risk management system in place. There are a range of policies, associated procedures, and forms in use to guide practice. Quality outcomes data are collected and analysed to improve service delivery. An internal audit schedule is in place. Adverse events when documented, are reported to management and external agencies.

The human resource management system is in place with policies to guide practice. There is an annual training plan in place that includes mandatory training. Caregivers complete dementia training.

There is a clearly documented rationale for determining staff levels and staff mix to provide safe service delivery in the rest home, hospital and the dementia unit.

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 clinical manager completes assessments, care plans and evaluations of care within required timeframes. Interventions are documented in detail with strategies to manage issues and needs. The registered nurse provides input into the process.

Each resident has access to an individual and group activities programme. The group programme is varied and interesting.

Medication is stored appropriately. An electronic system is used to record administration of medications. Medications for each resident are reviewed at least three monthly or as changes occur.

Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided. Residents and relatives interviewed were complimentary about the food service.

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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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. The internal and outdoor areas are safe and easily accessible with secure areas for those in the dementia unit.

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 service has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there were no residents using a restraint. Three rest home residents use an enabler to support their mental wellbeing.

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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The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated, and reported to relevant personnel.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	0	0	0
Criteria	0	40	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>	<p>FA</p>	<p>The complaints management policy and procedure is documented and follows Right 10 of the Code. The complaints policy and procedure is explained by the staff to residents and relatives as part of the admission process.</p> <p>There are complaint forms available at the main entrance to the building. A book in the cupboard allows staff to document any minor complaints that are resolved at the time the concerns are identified. This allows for the director/manager or assistant manager to monitor minor complaints to ensure that a pattern does not emerge.</p> <p>One complaint was documented on the register in 2020 (no others since the last audit). The emails from the complainant and the clinical manager show that the complaint was taken seriously and responded to immediately. The complainant (interviewed) stated that the complaint was taken seriously. Documentation provided to the complainant showed resolution in a timely manner.</p> <p>An up-to-date consumer complaints register is maintained.</p> <p>Staff interviewed (including four caregivers, a cook, director/manager, clinical manager, and diversional therapist), and residents and families interviewed have a good understanding of the complaints process.</p> <p>The director/manager and clinical manager confirmed that there have been no complaints from external authorities since the last audit.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The service provider has policies covering communication. Staff have access to interpreters as required.</p> <p>Three rest home residents, one resident from the dementia unit and four family interviewed, confirmed that the management team has an open-door policy and they all stated that they talk about any concerns with these resolved in a timely manner. This was observed on the day of audit with all staff and managers responsive to residents and family who had questions or concerns. Information is provided in a manner that the resident can understand.</p> <p>Resident meetings are conducted and provide an opportunity for residents and family members who choose to attend to discuss any concerns or positive changes in the service. The incident and accident forms include an area to document if the relatives have been contacted. Open disclosure is practised and documented when family are contacted.</p> <p>Residents and relatives interviewed confirmed that they are kept well informed, and that management and staff communicate in an open manner. Relatives confirmed that they are advised if there is a change in their family member's health status. The doctor interviewed reported satisfaction with communication by staff.</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>Killarney Rest Home is privately owned and operated. The director/manager purchased the facility in September 2014. The service provides care for up to 22 residents at rest home and dementia levels of care. On the day of the audit there were 13 residents requiring dementia level care (13 available beds), and eight residents using rest home level of care (nine available beds) including one resident under a long-term conditions contract and one under a mental health contract. Four residents are under the age of 65 years with all identified as being 'like' 65 years and therefore requiring the same level of care. One resident is under the Age-Related Care Contract in the dementia unit on a compulsory treatment order. The resident was able to be interviewed on the day of audit.</p> <p>The director/manager provides leadership and operational management along with a hands-on role in the service. Previously they owned another rest home for seven years. The director/manager is supported by an assistant manager who also worked at the previous rest home for seven years. The assistant manager has been in this role for six years, has previous experience as a caregiver in a rest home and dementia unit and provides 20 hours a week support.</p> <p>There is a clinical manager (registered nurse) who has over 19 years' experience working in aged care; has a postgraduate diploma in nursing and has experience as a team leader in a psychogeriatric unit. The director/manager and assistant manager have both completed at least eight hours of professional development related to management of an aged care facility and the clinical manager has completed at least eight hours of training relevant to the role.</p> <p>The business plan and annual goals indicate that the director/manager regularly reflects on achievements towards</p>

		<p>meeting these goals. An external consultant meets monthly and provides support and advice as required. Documentation of progress in the monthly management meetings confirms that the business plan and goals are reviewed regularly and annually. The purpose, values, priorities, and goals are documented in the annual business plan for 2020. The action points are signed off when completed and as per timeframes documented.</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 quality and risk management programme identifies objectives for the service. Activities within the programme are intricately linked with health and safety, adverse event reporting, the infection prevention and control programme, restraint minimisation, and the resident complaints process. Quality related data and outcomes are collated, analysed, and shared with staff at regular staff meetings. Goals documented in the quality plan include interventions with these reviewed as part of the ongoing quality review process.</p> <p>Policies are reviewed two yearly or as required, as defined by policy. The service uses an external quality and risk management consultant to provide advice on policies, procedures, and forms. Policies sighted reflect current good practice, legislation, and compliance requirements. All documents sampled are controlled, and obsolete documents removed from circulation. Policies and procedures and the internal audit schedule include reference to interRAI and care planning processes.</p> <p>Internal audits are planned and implemented as per the audit schedule. Corrective actions identified as part of the internal audit programme, are discussed at both management and staff meetings with evidence of resolution of issues in a timely manner. Staff sign the staff meeting minutes to indicate that they have attended or read the minutes if unable to attend. The external consultant is invited to attend the monthly management meetings with the management team, including the director/manager, assistant manager, and clinical manager in attendance. Data is analysed, and trends are discussed at both meetings.</p> <p>Satisfaction surveys are conducted with the last completed in March 2020. Thirteen respondents confirmed a high level of satisfaction with the service. Family and residents also have input into the service through the six-monthly review of care plans, with this stated by the director/manager and clinical manager as indicating again a high level of satisfaction with the service.</p> <p>There is a risk management plan documented. The risk register is maintained by the director/manager and the assistant manager. Health and safety requirements are being met, including hazard identification. Health and safety systems have been reviewed since the introduction of the Health and Safety at Work Act 2015. Staff could describe their role and responsibility as per the Health and Safety at Work Act 2015. Staff interviewed confirmed knowledge of the policy and stated that they are all responsible for health and safety including reporting of any issues as these arise.</p>
Standard 1.2.4:	FA	There is an established system in place for managing adverse events (both clinical and non-clinical). Ten incident

<p>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>forms were reviewed. The review confirmed that incidents and accidents were being reported and managed appropriately according to the incident itself. Any unwitnessed falls or where a head injury was identified or suspected, included completion of neurological observations for a sustained period of time. If the resident is unable to tolerate having neurological observations completed, then staff observe them closely with documentation in the progress notes. The clinical manager signs-off all incidents with actions documented if there was a need to review practice.</p> <p>The incident forms completed showed evidence of immediate responses, investigations and remedial actions being implemented as required. This included reporting to family members and informing the general practitioner or nurse practitioner as required.</p> <p>Monthly statistics on all documented adverse events are collated, analysed, and reported at the staff and management meetings. Trends are reviewed with changes to service delivery if relevant.</p> <p>The director/manager and clinical manager understand their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. No events have been externally reported 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>There is an established system in place for human resource management. Employment records were reviewed for the clinical manager, registered nurse, cook and two care staff. All records in the sample contained an employment agreement and a position description. The assistant manager stated that criminal vetting is not completed, as staff are employed after recommendation from others in the industry. Brief documentation of reference checking is completed, with this sighted in staff records for new staff.</p> <p>All staff requiring an annual practicing certificate have a copy of this on file. This includes confirmation of an annual practicing certificate for external health professionals involved in the care and support of residents, including the general practitioner, nurse practitioner, pharmacists, dietitian, and podiatrist.</p> <p>All staff receive an orientation and participate in ongoing training. A two-yearly training plan is documented and implemented. Staffing is stable, and staff interviewed were knowledgeable around their role. Performance appraisals are completed for all staff who have been employed for 12 months or more with each file reviewed including a current appraisal. The clinical manager and registered nurse are interRAI trained.</p> <p>All 12-caregiving staff who work in the dementia unit have completed training in dementia as per contractual specifications, apart from one caregiver who has resigned from the service.</p>
<p>Standard 1.2.8: Service Provider</p>	<p>FA</p>	<p>The process for determining provider levels and skill mix is defined in policy and this considers the layout of the facility and levels of care provided.</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>Staffing hours are flexible to meet the level of acuity of the residents. Staff rosters reviewed for the past two months confirmed that there is at least one caregiver in each area (dementia and rest home) at all times. An additional caregiver is scheduled on a short shift in the dementia unit in the morning and afternoon as required. Staff stated that managers and on call staff are very responsive to any request for additional staff.</p> <p>Rosters, staff interviewed and observation on the day of audit, confirmed there are sufficient numbers of staff in each area to meet resident need. Residents in both rest home and dementia chose to congregate in the dementia unit lounge with rest home residents having access in and out of the unit. The rest home residents are very conscious of safety and of ensuring that residents do not wander. Residents in the dementia unit are safe within the perimeter of the grounds and building and are not able to use the pin codes to wander out of the property. The configuration of the service allows for staffing to manage all residents at any given time.</p> <p>There are 21 staff in the service including the three managers who also provide hands-on care as required; diversional therapist (32 hours a week); two cooks; a cleaner and care staff with one caregiver also rostered as an activity's coordinator on two days a week. The clinical manager (registered nurse) is on site for 32 hours a week and provides on call support alternating with the registered nurse.</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>PA Low</p>	<p>The service uses an electronic medication management system. Ten medication charts were reviewed (four rest home and six dementia). There are policies and procedures in place for safe medicine management that meet legislative requirements. All staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff on the whole, were observed to be safely administering medications on the days of audit, however they were giving a number of residents' paracetamol elixir from one bottle as opposed to those prescribed to each individual resident. There were also some recently expired medications noted (removed during audit). The staff interviewed could describe their role regarding medicine administration. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>The medication fridge temperatures are recorded regularly, and these are within acceptable ranges. No vaccines are stored on site. Medication room temperatures are taken weekly. The clinical manager had completed regular audits of the electronic medication system.</p> <p>All medication charts sampled met legislative prescribing requirements. The medication charts reviewed identified that the GP or NP had seen and reviewed the resident three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	<p>FA</p>	<p>All meals at Killarney are prepared and cooked on site. There is a four-weekly seasonal menu, which has recently been reviewed by a dietitian and modifications made as per dietitian recommendations. Meals are delivered to the dining area. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free and</p>

<p>Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>diabetic desserts are provided. Cultural and religious food preferences are met. Nutritious snacks are available 24 hours a day for all residents.</p> <p>Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer, and chiller temperatures are monitored daily and recorded weekly. End cooked food temperatures are recorded daily. Food is stored correctly in the fridge, freezers, pantry, and dry goods areas and this is dated, labelled, and covered. Staff working in the kitchen have completed training in food safety and hygiene and chemical safety. The service has a current registered food plan with Ministry for Primary Industries (MPI).</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>When a resident's condition alters, the clinical manager initiates a review and if required, GP or NP consultation. The family members confirmed on interview they are notified of any changes to their relative's health, including accident/incidents, infections, health professional visits and changes in medications. This was recorded on the communications records in each resident record.</p> <p>In the residents' files reviewed, short-term care plans have been completed with a change in health condition and linked to the long-term care plan. Long-term care plans are reviewed six monthly.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Caregivers interviewed confirmed there is adequate equipment provided, including continence and wound care supplies. Wound assessments, plans and evaluation forms are documented whenever these are required (eg, for one resident with a stage two pressure injury and one resident with a skin tear). The clinical manager could describe access for wound and continence specialist input as required. Photographs are taken of wounds to document the healing process. For one resident, interventions have included accessing physiotherapy services and occupational therapy to assess equipment needs. That same resident has a hospital bed, a sensor mat and has been provided with a gutter frame that has helped their mobility. Staff stand the resident every hour to relieve pressure and support the resident to sleep with the use of 'as required' medication at midnight if they have not settled.</p> <p>Access to specialist advice and support is available and well used through the local DHB. Monitoring forms are in use such as weight, blood pressure and behaviour monitoring charts.</p> <p>There are close relationships with the Mental Health of Older Adults team and non-government organisations (NGOs) in the community. Residents are encouraged to be engaged with community activities and rest home residents interviewed, and observed access the community freely and frequently.</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>FA</p>	<p>A diversional therapist who has been with the service for five years works 32 hours per week and coordinates and delivers the programme for both service levels. They are supported by an activities coordinator who delivers the programme two days a week. Each provides activities for the different groups and one-to-one activities six hours a day, four days a week.</p> <p>A group programme is delivered in the dementia lounge for both service levels and residents interviewed stated that they like it this way. The rest home residents reported the group programme meets their needs, and participation is voluntary. The activities programme provides activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes pet therapy, van outings, church services, games, exercise programmes and happy hours.</p> <p>On the day of audit residents were observed participating in a variety of activities. One-on-one activities are provided by both the DT or caregivers for residents who are unable or choose not to be involved in group activities. There was evidence of activities that may be provided over 24hrs documented within the individual care plans for residents in the dementia unit.</p> <p>The diversional therapist is responsible for the resident's individual recreational and lifestyle plans, which are developed within the first three weeks of admission. The resident/family/whānau, as appropriate, are involved in the development of the activity plan. Resident files reviewed identified that the individual activity plan is reviewed at least six monthly alongside review of the care plan.</p> <p>Activities are planned that are appropriate to the functional capabilities of residents. Residents can provide feedback and suggestions for activities at the resident meetings and annual resident satisfaction survey.</p> <p>Residents and families interviewed reported satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>In the files sampled, the long-term care plans were evaluated at least six monthly or earlier if there is a change in health condition. There was at least a three-monthly review by the GP or NP. All changes in health status were documented and followed up. Short-term care plans were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress was different from expected, the service responded by initiating changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	<p>FA</p>	<p>The building has a current building warrant of fitness. The building has two lounge areas with two outdoor garden/patio spaces suitable for residents in both the rest home and dementia unit. The director/manager is managing the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed within 43-45 degrees Celsius.</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>The facility has sufficient space for residents to mobilise using mobility aids. The external areas are well maintained. Residents have access to safely designed external areas that have shade. The dementia unit outdoor area is secure. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>	<p>FA</p>	<p>The clinical manager is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (eg, facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes are in place and documented. The service has very few infections and if there are infections, these are mostly documented as being acquired from hospital visits.</p> <p>All visitors or contractors are required to sign in on entry to the service and to complete a health check form which also serves as contact tracing. Residents and staff are offered the annual influenza vaccine. There are adequate hand sanitisers. There is an outbreak management bin and stock of personal protective equipment that is able to supply staff and residents with personal protective equipment for at least two weeks. Staff have increased cleaning of the facility and education has been provided on a regular basis during the pandemic to staff around Covid 19. Visitors were restricted during periods of lock down. Family have been kept informed of any changes and residents were encouraged to engage in phone conversations with family during lock down.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Staff interviewed, observations, and review of documentation, demonstrated safe use of restraint or enablers. The service has a policy of actively minimising restraint. The service has a documented system in place for restraint and enabler use, including a restraint register. There are no residents using restraint in the rest home or dementia unit and three residents using an enabler. The enablers are identified as locks on bedroom doors with residents wanting to lock their door so other residents do not enter their rooms. Risks of using the device have been explained to each resident and documented. The locks on the bedroom door are able to be unlocked by staff and give these residents a sense of mental wellbeing.</p> <p>The restraint coordinator is the clinical manager. An interview with the restraint coordinator confirmed knowledge of restraint and use of enablers. They also described discussion of any potential use of restraint or enablers in meetings held monthly with documentation in minutes confirming this.</p> <p>Staff have at least annual training in management of challenging behaviour. Staff interviewed were able to describe management as per policy with this individualised according to the specific individual resident and strategies</p>

		documented in care plans.
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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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Staff described a process for checking expiry dates on medications. There were however some identified on the trolley and in the cupboard in the medication room that had been missed and had expired. Staff also used one bottle of paracetamol elixir instead of individual bottles prescribed to the individual resident.	<p>i) Some medicines had recently expired but were still in use.</p> <p>ii) One bottle of elixir is used when administering medications instead of individual bottles prescribed to the individual resident.</p>	<p>i) Implement a process to ensure that expired medications are returned to the pharmacy.</p> <p>ii) Ensure that each resident has medicine from that prescribed to them.</p>

				90 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.