Waihi Lifecare (2018) Limited - Waihi Lifecare

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:	Waihi Lifecare (2018) Limited
Premises audited:	Waihi Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Hospital services - Maternity services
Dates of audit:	Start date: 12 July 2021 End date: 12 July 2021

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: 43

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

Waihi Lifecare provides rest home, hospital level care and primary maternity services for up to 44 residents. The service is operated by Waihi Lifecare (2018) Limited and managed by a facility manager and a clinical nurse lead. Residents, women and families spoke positively about the care provided.

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 staff and residents' records, women and baby's records, observations and interviews with residents, family members, management, staff, contracted allied health professionals and a general practitioner.

There were two corrective actions to follow-up from the previous report and these have been addressed and closed out. This audit has resulted in one area requiring improvement relating to service delivery and timeliness of interRAI assessments being completed.

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.

Staff and management are adhering to the principles and practices of open disclosure. Access to interpreters is available if needed.

The complaints register is maintained with complaints resolved promptly and effectively. Feedback is provided to staff and quality improvements are initiated and implemented as needed.

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.

Business and quality and risk management plans included the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the owner/directors was 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. There are adequate experienced staff to cover the maternity annexe.

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.

Each stage of service provision is managed by suitably qualified personnel who are competent to perform the function they manage. 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/women and babies are reviewed and evaluated on a regular basis.

The planned activities provide 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. Activities provided to women in the primary maternity service involved parenting education and health promotion.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents/women 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.

There was a current building warrant of fitness displayed at reception.

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.

Waihi Lifecare has implemented policies and procedures that support the minimisation of restraint. Two enablers and four restraints were in use at the time of the audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff interviewed demonstrated a sound knowledge and understanding of the organisation's restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.

The infection surveillance undertaken is appropriate for the size and type of the facility. Infection results are 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	16	0	1	0	0	0
Criteria	0	41	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints/concerns/issues policy and associated forms meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents, families and women on admission to Waihi Lifecare and to the maternity annexe and those interviewed knew how to do so. A feed-back form is provided to all women who access the maternity service. The complaints register reviewed showed that no complaints have been received over the past year. Three external issues one of which currently remains open involved the New Zealand Police. Two trespass notices were put in place (one still remains) and one other issue was a security issue and this has been closed out. Records demonstrated that actions were taken, through to an agreed resolution, are documented and completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. There is one Health and Disability Commissioner's (HDC) complaint in the register, which was followed through and was effectively closed out on the 13 April 2021. Quality learnings and outcomes were fed back to staff, and this was verified in the minutes of the quality and staff meetings. The facility manager is responsible for complaints management and follow up. All staff, maternity aides and an LMC interviewed confirmed a sound understanding of the complaint process and what actions are required.
Standard 1.1.9:	FA	Residents and family/whanau members stated that they were kept well informed about the changes to their/their

Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.		relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any medical reviews. This was supported in the resident's individual records reviewed, and in the women's records in the primary maternity service that were retrieved from the recent archived records for review on the day of the audit. There was also evidence of resident/family input into the care planning process. Staff and the lead maternity carer (LMC) midwife interviewed understood the principles of open disclosure, which is supported by policies that meet the requirements of the Code. Interpreter services can be accessed via the DHB or locally when required. Staff interviewed knew how to do so, although reported this was rarely required due to the use of family members.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business quality and risk plan is reviewed annually. The plan outlines the mission statement/philosophy and goals of the organisation. The documents described annual and longer term objectives for all areas of service provision. A sample of monthly reports showed adequate information to monitor performance is reported to the two owner/ directors including finances, emerging risks and staffing and/or any impending issues. The service is managed by a facility manager (FM) who is an experienced registered nurse and has only been in this role for three months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The FM interviewed confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through attending study days and information provided by the DHB. The directors and the facility manager expressed a commitment to working with staff, women, the Waikato District Health Board (WDHB) and Bay of Plenty District Health Board (BOPDHB), lead maternity carers (LMCs) and the community to promote and continually improve the primary maternity service. The numbers of women birthing or receiving postnatal care has increased since the previous audit. Staff and women interviewed were pleased with the refurbishment of the facility and the ongoing care provided by staff and midwives. A maternity care assistant (who reports to the FM) ensures the day to day running of the facility with input from the midwives providing the primary maternity care services. The FM is responsible for the overseeing of the maternity annexe. The FM is supported by the clinical nurse lead (CNL). The service holds contracts with the DHB for rest home, hospital (geriatric/medical), GP, respite, and primary maternity care services. On the day of audit there were twenty six rest home level care residents, sixteen hospital level, no respite, GP or maternity care residents. There was one resident on an individual Accident Compensation Corporation contract (ACC). Six beds are designated dual purpose beds.
Standard 1.2.3: Quality And Risk Management	FA	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, a regular patient satisfaction survey, monitoring of outcomes, falls, medication errors, resident behaviours causing concern, near misses, clinical

Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		incidents including infections and restraint minimisation and safe practice. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings held monthly. The FM reports to the directors monthly but meets with one of the two directors weekly on-site at the hospital. Staff reported their involvement in quality and risk management activities through internal audit activities, and the quarterly facility health check completed by the maintenance personal. The annual satisfaction survey of residents is completed in September each year. The 2020 satisfaction survey provided positive responses and comments from residents/family. A staff satisfaction survey was completed in March 2021. 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. This is managed by a contracted quality coordinator and any new policies/procedures are authorised and signed off by one of the two directors. The FM is responsible for ensuring that any new or revised policies are put out for staff to view and when signed off ensures these are placed into the current system and any obsolete documents are filed and stored appropriately. The maternity annexe policies and procedures are reviewed in consultation with the LMCs and maternity care assistants have input as verified by staff interview. The organisation has four years Baby Friendly Hospital Initiative (BFHI) accreditation and records are being maintained by the lead maternity care assistant who reports to the FM and LMCs. The FM interviewed 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. The hazard identification and risk monitoring system was reviewed electronically and all risks are categorised. The hazard register was sighted and was current and up-to-date.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected	FA	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported by the clinical nurse lead to the FM monthly. The FM described essential notification reporting requirements, including for pressure injuries. The FM advised there have been no Section 31 notification of a significant event made to the HealthCERT since the previous audit. There have been three external contacts with the New Zealand Police one was a security breach, two were regarding trespass notices since the previous audit. One trespass notice is in place currently the other two incidents are closed out effectively. After a discussion with the FM a section 31 notice was arranged on the day of the audit for the recent security breach (maternity service) and sent directly to HealthCERT. HealthCERT had been notified of

consumers and where appropriate their family/whānau of choice in an open manner.		the change of manager.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	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. The LMCs access agreements were current. Staff orientation includes all necessary components relevant to the role. A workbook is completed by staff relevant to the role to be undertaken. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation. 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. The previous manager has remained as the designated internal assessor for the programme. There are 30 healthcare assistants (HCAs) employed currently with seven HCAs having completed level 2, seven level 3 and eight level 4. Thirteen (13) HCAs are currently enrolled undertaking more training. The two diversional therapists interviewed have completed diversional therapy level 4. There are five of seven 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. Additional training is provided for the ten (10) maternity care assistants who work/cover in the maternity annexe. Records of training are maintained. All staff receive training in relation to obstetric emergencies and staff interviewed are aware of the obligations and responsibilities. The contact details of all LMCs are readily available.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled	FA	The staffing availability policy was reviewed. This includes a framework for managing residents' needs and staffing. The FM is responsible for completing the rosters reviewed. The roster is appropriate for the size and nature of the services provided with shifts covered by a registered nurse at all times. For the maternity annexe, a roster is developed to ensure cover is available twenty four hours a day, seven days a week (24/7) when women are present. Staff are otherwise rostered and on call. The FM is supported by a lead maternity carer for applicable issues. The maternity care assistant interviewed is responsible for ordering, restocking, cleaning and laundry services, providing food and fluid and provision of care under the direction and delegation of the lead maternity carer and other tasks as required. A second midwife provides backup support to the

and/or experienced service providers.		LMC during births. When a woman is being admitted to the service the maternity care assistant opens and prepares the maternity annexe in readiness. The current system works effectively and efficiently as reported by the LMC interviewed. All registered nurses are provided with a rostered 'paper day' a month to ensure the interRAI assessments are completed and/or the care plans are updated in a timely manner. Registered nurses are rostered onto all shifts and HCAs are rotated around the hospital/rest home accordingly. Specifically interested and trained maternity care assistants cover the maternity service. The roster verifies unplanned absences are covered by staff. Staff can request days/shifts off. Women interviewed confirmed staffing was appropriate to meet their needs. Residents and families interviewed supported that adequate staff cover was available to meet the needs of the residents.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	A safe electronic medication management system was observed on the day of the audit. The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care and meets legislative requirements. Staff who administer medication had current medication administration competencies. The RN who was observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked cupboards in the medicine room and the medicine trolley. Staff have individual passwords to access the electronic medicine records. The medicine fridge and medication room temperatures were monitored, and the reviewed records were within the recommended ranges. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN completes medication reconciliation upon residents' readmission from acute services and when medication is received from the pharmacy. There were no expired medicines stored in the stocks sighted. Clinical pharmacist input is provided on request. Unwanted medicines are returned to the pharmacy. Controlled drugs were 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. The GP completed three-monthly medication reviews consistently, as verified on electronic medicine charts reviewed. Dates were recorded on the commencement and discontinuation of medicines. Evaluation of pro re nata (PRN) medicines administered were completed consistently. Current residents' photos were uploaded into the electronic management system. There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner when required. The medication records reviewed in the maternity annexe were completed for both the mother and the baby on

		separate medication records. Both medication record sheets are prepopulated but signed and dated when prescribed by the LMCs. No errors have been reported in regard to medicine management in the maternity annexe. No controlled drugs are kept on site and minimal supplies of medicines are stored on site. Emergency medication is checked regularly and after use.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Residents' nutritional needs are identified on admission by the RNs and diet profiles are completed. Special dietary requirements, including likes, dislikes and allergies were identified and accommodated in the meal plan. Copies of the dietary forms were sighted in the kitchen file. Special equipment to meet residents' nutritional needs was available. There are two chefs and three kitchen hands responsible for food services provided on site. The chefs have completed a food handling qualification and the kitchen hands have completed safe food handling training. The food service is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns in a four-weekly cycle. The menu has been reviewed by a qualified dietitian on 24/02/21. Recommendations made at that time have been implemented. The service operates with an approved and current food safety plan and registration issued by the local district council. An external food verification audit was completed on 14 June 2021. Food temperatures were monitored appropriately and recorded as part of the plan. Fridge and freezer temperatures were monitored and documented as required. The kitchen was clean, no expired food was found in the pantry and left-over food was covered and dated. Completed kitchen cleaning schedules were sighted in the kitchen folder. In maternity, the food service is managed from the hospital kitchen and women complete daily menus. Choices are provided and any special dietary needs are addressed. The women interviewed stated the meals are homely and adequate. Additional food is provided for the after-hours and to meet the needs of women. The residents and family reported satisfaction with the food service, and this was verified in the satisfaction surveys sighted. On the day of the audit, residents were given enough time to eat their meal in an unhurried fashion.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	A primary nurse is appointed for each resident within the qualified nursing team. The primary nurse is responsible for developing a therapeutic relationship with the resident, reviewing their progress at regular intervals and providing a more in-depth insight into the resident or family's needs. The interventions documented in the long-term care plans reviewed were adequate and appropriate to address residents' assessed needs and desired outcomes. Observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of residents' individualised needs was evident in all areas of service provision. The GP confirmed that medical input was sought in a timely manner, and care was provided as prescribed. Adequate equipment and resources were available to meet the residents' needs. The LMC midwife is responsible should any intervention be required during all stages of service provision for the

		mother and/or the baby. Goals are set post birth for both the mother and the baby for the postnatal stay. Cultural needs are considered at all times and were reflected on the individual care plans reviewed. A whanau and/or nominated support persons are encouraged to stay, with the consent of the women.
Standard 1.3.7: Planned Activities 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.	FA	The activities programme is provided by two qualified diversional therapists (DTs). The DTs complete the activities programme monthly with input from residents. Activities assessments and care plans are completed by the DTs for all residents with input from residents and family/whanau within four weeks of admission. The monthly activities calendar is posted on the notice boards around the facility. Any changes or updates on the activities programme is discussed in weekly head of department meetings. The family/whanau are welcome to participate in activities with their family/relative. The activities on the schedule reflected ordinary patterns of life, were specific to the cultural needs of the residents and included community activities. Residents can participate in individual or group activities as desired. The DT reported that individual activities are offered for residents who are unable or unwilling to attend to group activities. Activities are scheduled for rest home level residents and for hospital level residents. Residents are free to attend to activities of their choice either in the rest home or in the hospital area. Residents were observed participating in various activities on the day of the audit. The activities on the calendar include birthday celebrations, external entertainment, van outings, 'happy hour', assisted walks, quiz, puzzles, exercises, arts and crafts and baking. Special activities were provided for residents with vision impairment. The residents' participation in activities were recorded daily and monthly progress notes were completed by the DTs. The residents' activity needs were evaluated as part of the formal six monthly interRAI and care plan review. The satisfaction survey verified residents' and family involvement in evaluating and improving the activities programme. The interviewed residents and family confirmed residents' satisfaction with the activities programme. The maternity services activities are not structured or organised as such due to the nature of this primary birthing service. All support is provided during the time the women and their babies are in the annexe. Parenting education is a major activity and staff use every opportunity to promote health education activities, Topics such as safe sleeping practices, smoking cessation, settling babies, baby bathing demonstrations and positioning and latching techniques for successful/breastfeeding are promoted, demonstrated and encouraged. Educational resources and brochures are available in the reception area for couples to access. Women interviewed stated that they enjoyed the relaxed peaceful atmosphere where self-care and caring for their baby was encouraged and promoted. Staff interviewed stated they enjoyed this aspect of promoting and providing healthy options for the women, babies and support persons
Standard 1.3.8:	PA Low	A schedule for routine care plan evaluation was sighted and the clinical nurse leader prints out a list of interRAI reassessments that are due each month. The interviewed RNs and DTs confirmed this and were aware of the care

Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.		plans and interRAI reassessments due for each month. Long-term care plans and short-term care plans were evaluated by the RNs. However, two out of five routine care plan evaluations were not completed in a timely manner and six routine interRAI reassessments were overdue. The interviewed residents and family confirmed their involvement in the evaluation of progress and resulting changes. The long-term care plans sighted were signed by residents and family or enduring power of attorney where indicated. The postnatal care plans for both mother and baby are updated daily by the LMC midwives and the progress records at each point of contact by the maternity care assistants. Any changes observed are reported to the LMC and acted on immediately. If a transfer is required, full support is provided by the maternity care assistant and the registered nurse if applicable. The LMC has to accompany the mother and/or the baby if a transfer is to be arranged.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	An area of improvement identified at the previous audit in relation to a sluice room in the newly renovated area has been effectively addressed. This area is functioning efficiently and adequate personal protective equipment and resources are readily available for staff to access.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	The building warrant of fitness was validated and is dated the 24 April 2022. This is framed and displayed in public view at reception. A corrective action from the previous audit in relation to appropriate lifting and mobility equipment being available to meet the needs of the residents and has been fully addressed. Handrails were checked and installed to promote and maximise residents' mobility and independence.

for their purpose.		
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection surveillance carried out is in accordance with the agreed objectives specified in the infection control programme and is appropriate for the size and setting of the service. The infections being monitored include skin, urinary tract, chest, wound and oral infections. All identified infections were documented, monthly data was collated and analysed. Recommendations and corrective actions to assist with reducing and preventing infections were acted upon. Short term care plans were implemented with appropriate interventions to manage the identified infections. New infections and any required management plans were discussed at handover, to ensure early intervention occurs. Monthly surveillance results were shared with staff in staff meetings and weekly managers meetings. Comparisons against previous months and benchmarking against two other facilities were conducted and the reviewed infection statistics evidenced minimal infection rates. If a woman was admitted to the maternity annexe with an infection this would be reported to the infection control nurse. There have been no infection related issues reported since the previous audit from the primary maternity service. COVID-19 pandemic contact tracing measures were implemented. There was no infection outbreak reported since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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 provides support and oversight for enabler and restraint management in the facility and demonstrated a good understanding of the organisation's policies and procedures, the role and the responsibilities involved. On the day of audit four residents were using a restraint and two enablers were in use. Enablers are the least restrictive and can be used voluntarily at the request of the resident. A similar process is followed for the use of enablers as is used for restraints.

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)
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.	PA Low	Three out of five care plan evaluations sighted were completed six- monthly. The documented evaluations were individualised and indicated the residents’ degree of response to the interventions and progress towards achieving the desired outcome. Changes were made to the care plans where the desired goal was not met. However, two out of five care plans reviewed were not evaluated in a timely manner. Six interRAI reassessments were overdue. New RNs were employed and have completed interRAI training. There is adequate RN cover now to manage the care plan evaluations and interRAI reassessments. The clinical nurse leader reported that plans are in place to ensure the overdue interRAI assessments and care plan evaluations are completed.	Six-monthly interRAI reassessment were overdue routine review with interval of between four to eight weeks. Routine six-monthly care plan evaluation for two resident’s files reviewed were not completed. Click here to enter text	Ensure all assessments and long-term care plans are undertaken as per ARRC contract requirements. 180 days

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.

No data to display

End of the report.