Elsdon Enterprises Limited - Annaliese Haven 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 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:	Elsdon Enterprises Limited
Premises audited:	Annaliese Haven Rest Home
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 22 August 2017 End date: 22 August 2017

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: 47

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

Annaliese Haven Rest Home provides rest home and dementia level care for up to 63 residents. The service is operated by a private company and managed by a facility manager and a clinical services manager. Residents 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 residents' and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

This audit has resulted in the identification of areas requiring improvements relating to care planning, assessments and medication management. Improvements have been made to 13 of the 14 areas requiring improvement at the previous audit.

Consumer rights

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

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints 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.		Standards applicable to this service fully attained.

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

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on an ongoing basis. Service delivery 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 is consistent with the outcomes of a range of assessments and the identification of residents' needs.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. The needs of dementia service residents are being met with multiple examples of one on one support.

There are planned processes for the evaluation and review of residents' short and long-term care plans and for activities plans.

Medicines are safely managed and administered by staff who are competent to do so. The medicine management system is supported by the use of an electronic system, which has successfully reduced the incidence of medicine errors as intended.

Meals are prepared on site according to a four-weekly rotating menu that has been approved by a dietitian. Residents with special dietary needs or personal preferences have these met. Food is being safely managed during storage and preparation processes. Residents and family 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 is a current building warrant of fitness. The facility meets the needs of residents and external areas are accessible, safe and provide shade and seating. Chemicals, soiled linen and equipment are safely stored. Staff are trained in emergency procedures, have access to emergency equipment and supplies and attend regular fire drills.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints are in use at the time of audit. Staff demonstrated a sound knowledge and understanding of the 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.

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	18	0	2	1	0	0
Criteria	0	42	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	A review of records demonstrates that written consent is obtained where required meeting a previous required improvement. All consent forms reviewed are consistent with legislative requirements.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is	FA	The complaints/concerns/issues 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. The complaints register reviewed showed that six complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans

understood, respected, and upheld.		show any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. T There have been two complaints received from external sources since the previous audit. One was resolved immediately to the satisfaction of the complainant. The previous 2016 complaint was resolved in May 2017 with four recommendations all implemented by the service.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.
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 strategic and business plans, which are reviewed annually, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of monthly reports to the owners showed adequate information to monitor performance is reported including occupancy rates, staffing and adverse event reporting. The service is managed by a facility manager who holds relevant qualifications and has been in the role for two years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attending sector meetings and quality seminars. The service holds contracts with DHB for respite, rest home and dementia care. Forty-seven residents were receiving services under the contract at the time of audit. There were 20 rest home level residents, including one on respite, and twenty-seven residents in the dementia service, also included one respite. There were no residents at hospital level, although dispensation for a resident had previously been granted, the resident was no longer at the facility. The provider intends to reconfigure the service to increase rest home and reduce the number of dementia beds with an overall reduction of two beds. The alterations have not commenced at the time of the audit.

Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	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, an annual resident satisfaction survey, monitoring of outcomes, and clinical incidents including infections. Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and risk team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, and feedback via staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey showed a high level of satisfaction with resident care. As the surveys have only recently returned (July), a full analysis has not yet occurred. 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. The facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
Standard 1.2.4: Adverse Event Reporting 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.	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 to quality meetings and the owners within a monthly report. The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health since the previous audit.
Standard 1.2.7:	FA	Human resources management policies and processes are based on good employment practice and relevant

Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.		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. Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review after a three-month period. The facility manager now has the required training and experience required, meeting a previous required improvement. 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. Staff working in the dementia care area have either completed or are enrolled in the required education. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. At least one staff member on duty has a current first aid certificate. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals addressing a previous shortfall.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An after-hours 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. Residents and family members interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with	PA Low	Overall, the medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. However, the documents do not reflect the current electronic medication system currently in place and this has been raised for corrective action. Although this is a new corrective action it is of low risk as a full 'One Chart' manual is available, and all staff using it have been fully trained in its use. Hence, a reduced timeframe has been allocated to ensure this is addressed promptly. Previous medicine related issues that were raised for corrective action at the last audit had been satisfactorily addressed. Use of the electronic medicine management system management was observed on the day of audit. The staff

current legislative requirements and safe practice guidelines.		person observed and the clinical care manager demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. According to staff training records, all staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. Two nurses check the medications against the prescription on arrival at the facility and there were signed records of this practice. All medications sighted were within current use by dates and the process for removing medicines that are out of date, or no longer required was described. Clinical pharmacist input is provided monthly, including for verification of the controlled drug records. 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. The records of temperatures for two medicine fridges were reviewed and had been within the recommended range. Use of the electronic medicine management system is ensuring good prescribing practices are being upheld. The required three-monthly GP review is consistently recorded on the medicine record and in resident's personal files. There were two residents who were self-administering their medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner with three monthly competency reviews by the person's GP and the person administering medicines double checks that the medicine has been taken. There is an implemented process for comprehensive analysis of any medication errors and appropriate actions are taken when this is required.
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	A nutritional assessment, followed by a dietary profile, is completed for all residents on admission and these were sighted in residents' files. Kitchen staff informed during interview that they are provided with documentation about specific dietary needs of residents and that staff update these when necessary. Records of this information were sighted, as was a white board with individual likes and dislikes listed on it. Examples of specific needs included vegetarian food, awareness of a person with diabetes and changes in food textures such as soft or moulied food. Residents who were able to respond, confirmed their food needs are being met. The previous corrective action related to the needs of residents with specific dietary requirements has been addressed with implementation of these systems. Food services are provided on site by a team of kitchen workers who share cook and kitchenhand duties. The menu rotates every four weeks, has been reviewed by a qualified dietitian within the last two years and its components have been confirmed as being in line with recognised nutritional guidelines for older people. Although the master menu is used throughout the year, the cook described how variations are added when relevant such as for celebrations and additional salads being added in summer.

		All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. This is occurring in both serving areas. Fridge temperatures are checked and recorded with actions taken when they read outside expected parameters, food is dated when not used immediately and frozen goods are sealed. Kitchen staff have completed training in safe food handling practices. A corrective action raised at the previous audit around unsatisfactory aspects of food management has been addressed. Sandwiches, baking and fruit are available over a 24-hour period and staff may provide these to any resident if the person is hungry or unsettled. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Feedback about the meals from residents and relatives was positive with more than one comment about it being 'just like we had at home'.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All residents had a completed initial interRAI assessment on file. A range of assessment processes are now being used to identify the needs, outcomes and/or goals of the residents. These include for falls risk, nutrition, pressure area risk, pain and behavioural characteristics. The information obtained is being used to guide the interventions in service delivery plans and in behavioural management plans. Issues of concern around assessment processes that were raised at the last audit were no longer apparent, although there is a gap in some re-assessments for six monthly reviews, which has been raised in the corrective action under criterion 1.3.8.2.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Low	A corrective action was raised at the last audit as a number of residents did not have satisfactory care plans. This is no longer an issue as all residents had a care plan. Likewise, the need for use of a Maori model of health, such as Te Whare Tapa Wha is no longer an issue, as it is clearly documented in the care plan of all who identify as Maori as to whether the person's relative considers this will be a useful tool for the resident concerned. All residents' plans reviewed reflected the support needs of residents and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in the goals and interventions in the care plans and activity plans reviewed. Care plans evidence service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. However, active short-term care plans, food and fluid charts, continence and voiding records, sleep charts, behaviour charts, turning/position shifting and bowel charts are not integrated into the wider personal file until they are finished with and archived. This has been raised for corrective action. Any change in care required is documented and verbally passed on to relevant staff. Residents and families

		reported participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. This was especially evident in the two tracers undertaken and in the extended sample. Staff were observed to respond appropriately to physical and emotional changes in residents on more than one occasion throughout the audit. Through their interventions, staff are meeting a diverse range of resident's individualised needs and this was evident in both the rest home and dementia services. Family/whanau spoke of the sensitivity of staff and the gentle handling of their loved ones. The GP interviewed, verified that medical input is sought in a timely manner, that as far as he knows medical orders are always followed through, and care is 'fantastic, especially considering the challenges that go with providing dementia care in the same facility as rest home care is provided'. Care staff confirmed that care was provided as outlined in the documentation and according to instructions from registered nurses. The importance of the activities team was noted by residents, and families/whanau and care staff. Importance of the environment and changes made to accommodate the needs of current residents was discussed with the clinical care manager who is also ensuring that suitable equipment and resources are available.
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 trained diversional therapists holding the national Certificate in Diversional Therapy, one trainee and one assistant. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. A four-week programme was on display and included a range of activities varying in nature from cultural/spiritual, social, intellectual, physical, community and personal. The diversional therapist noted this is changed each month and may vary according to the season or if there is any special celebration. New documentation has been implemented for residents' activity plans and the individual plans are being completed in a comprehensive manner with clear goals and interventions. Individual records of attendances at activities are being kept and three monthly narrative reviews about their participation are documented. Twenty four hour activity plans are in place for residents and the activity needs of residents are evaluated as part of their formal six monthly care plan review. There are some gaps in these review systems as noted in the corrective action for criterion 1.3.8.2. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are asked for comment about the programme and family members may be involved at the level they choose. One family member reported such involvement and the increased insight this had provided. Residents interviewed, and who were able to respond, confirmed they find the programme diverse and that there is always something interesting to do.

		Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless such as evenings, or according to individual characteristics. This includes music, reading, walks, one on one engagements and simple household tasks. Staff were observed coordinating activities and there was good evidence that the residents were interested and participating at their level of ability. There were signs of contentment and involvement.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	Resident care is evaluated on each shift and reported in the residents' individual progress notes. If any change is noted, it is reported to the registered nurse and included in the verbal handover that occurs between staff on each shift. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment and as residents' needs change. Records sighted demonstrated that not all required review processes have been completed within the required timeframes, which was an issue raised at the previous audit. Although efforts have been made to remedy this situation, the team has not yet achieved the expected results and the corrective action remains open. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were sighted for infections, skin tears and weight changes. When necessary, and for unresolved problems, long term care plans are subsequently added to and updated. There was evidence in family communication records in residents' files that families/whanau are invited to multidisciplinary meetings for the review of service delivery plans. A family member informed of examples where staff have involved them in the interventions and review processes and the GP noted that families are contacted after his visits and updated as required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date 01 June 2018) is publicly displayed. External areas are now safely maintained and are appropriate to the resident groups and setting, addressing a previous required improvement. All external areas, including the smoking area, are freely accessible during the day and electronically secured at night. Family and residents confirmed and were observed accessing the outside areas.
Standard 1.4.6: Cleaning And	FA	Laundry is undertaken on site and laundry processes, dirty/clean flow and handling of soiled linen now meets recommended guidelines and policies. Trolleys are observed to be covered, addressing a previous shortfall. During

Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		interview cleaning staff confirmed this is a consistent process.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The facility now has access to alternative energy and utility sources in the event of the main supplies failing, addressing a previous shortfall. There is sufficient stored water in case of emergency, door locking mechanism ensures the building remains secure, and first aid kits have content lists and these are regularly checked. This addresses previous required improvements.
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	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The IPC coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. 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 via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, quality committee and the owner. Data is benchmarked externally with other aged care providers. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation	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 sound understanding of the

Services demonstrate that the use of restraint is actively minimised.		organisation's policies, procedures and practice and her/his role and responsibilities. On the day of audit, no residents were using restraints or enablers. The last use of bedrails as an enabler was 20 August 2017. The facility has not used 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 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine	PA Low	All practices around medicine management including safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation comply with legislation, protocols, and guidelines and reflected good practice. Medicine management policies and procedures had been reviewed in March 2017 and were therefore current. However, it was observed that these documents do not reflect the use of One Chart, an electronic medicine management system that is currently in use.	The current medicine management policy and procedure does not include the organisation’s use of One Chart for the administration of medications.	The medicine management policy and procedures need to reflect the electronic medicine management system currently in use. 90 days

reconciliation in order to comply with legislation, protocols, and guidelines.				
Criterion 1.3.5.3 Service delivery plans demonstrate service integration.	PA Low	A registered nurse diary currently in use is being used to assist with the handover process and includes a list of clients and in some cases a full progress report on the status and ongoing interventions for residents. This is not only compromising resident confidentiality but is also dividing records between residents' personal notes and a second form of record, which is not consistent with the requirement for an integrated record. In addition, each resident has a folder for their records that contains personal information, interRAI assessment documents, medical notes, the care plan and activity plan, test results and referral letters for example. A separate folder holds collective records with a range of other personal information that includes active short-term care plans, food and fluid charts, continence and voiding records, sleep charts, behaviour charts, turning/position shifting and bowel charts. It is understood from staff that this collective information system has meant these documents are now filled in as required, whereas this was not happening when in their folders. Although the records are archived into the person's folder, the extent of the separation of this personal information is not enabling a true integrated record intended to ensure fully individualised care for each resident. Although there was no evidence to suggest that residents' care is compromised from this practice, the potential is there, and therefore the need for service delivery plans to demonstrate service integration is an area for review and corrective action.	The standard requires that service delivery plans demonstrate service integration. A registered nurse diary contains lists of residents' names followed by the equivalent of progress reports against them, rather than prompting the staff to refer to the resident's record. In addition, residents' personal documents including short term care plans, behaviour charts, continence records and nutrition records are held in a single folder, rather than in the person's files.	Residents' service delivery plans are structured in such a manner that demonstrates service integration and ensures personalised and individualised care will be consistently delivered. 180 days
Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the	PA Moderate	The clinical care manager described the task since she took on the role just over a year ago of bringing the evaluation and review processes up to date and ensuring all residents have a current care plan. This created a significant workload. Systems have been restructured and there was evidence of progress having been made towards ensuring interRAI assessments for evaluation and review processes are up to date and that long and short term care plans are updated. Staff were familiar with	Not all key evaluation and review processes including interRAI re-assessments, service delivery plan reviews and 24-hour activity plans (dementia service) are current.	Evaluation and review processes are undertaken within required timeframes to ensure all

degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.		the needs of individuals and positive feedback about the level of care provided was forthcoming. However, there are still overdue six monthly interRAI assessments, outstanding care plan evaluations/reviews and old versions of non-compliant 24-hour activity plans that need to be updated. The corrective action raised at the previous audit remains open.		residents have a current interRAI assessment, a current service delivery plan and that dementia residents have a 24 hour activity plan that meets contractual requirements. 90 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.