

# Christchurch Methodist Central Mission - WesleyCare

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## 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 Health and Disability Auditing New Zealand 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:

<b>Legal entity:</b>	Christchurch Methodist Central Mission
<b>Premises audited:</b>	WesleyCare
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 18 September 2019    End date: 19 September 2019
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	103

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

## General overview of the audit

WesleyCare is governed by the Christchurch Methodist Mission board. An executive director is responsible for all aspects of the mission. The residential aged care service provided at WesleyCare is one of five aspects of the boards work. WesleyCare provides care for up to 108 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 103 residents in total.

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, family, management, staff and the general practitioner.

The facility manager has many years working at WesleyCare in the role of manager. The manager is also supported by an acting quality manager/RN, two clinical nurse managers, registered nurses and care staff. Residents and family interviewed were very complimentary of the services and care they receive.

The two previous audit shortfalls around timeframes and care plan interventions continue to require improvement.

This audit identified further improvements required around staff files and education.

## 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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Information about services provided is readily available to residents and families/whānau. The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) brochures are accessible to residents and their families. There are resident meetings and a resident advocate available. Complaints processes are implemented and managed in line with the Code.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The quality and risk management plan and quality and risk policies describe WesleyCare's quality improvement processes. Policies and procedures are maintained by an aged care consultant who ensures they align with current good practice and meet legislative requirements. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys. Quality data is discussed at meetings and is documented in minutes. There are human resources policies including recruitment, selection and orientation for new staff. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Registered nurses are responsible for each area of service provision including assessments, care plans and evaluations. The residents' needs, interventions, outcomes/goals are reviewed on a regular basis with the resident and/or family/whānau input. Care plans demonstrated service integration. Resident files included notes by the GP and allied health professionals.

Medication policies and procedures are in place to guide practice. Education and medication competencies are completed by all staff responsible for administration of medicines.

The activities programme is facilitated by diversional therapists. The activities programme provides varied options and activities are enjoyed by the residents. The programme caters for the individual needs and involves community activity.

All food is cooked on site by the in-house chef and cooks. All residents' nutritional needs are identified, highlighted and choices are available and provided, meals are well presented. There is a current food control plan. Residents commented positively on the meals provided.

## 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. There is a reactive and planned maintenance system.

## 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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There is a restraint policy that included comprehensive restraint procedures and aligns with the standards. A register is maintained with all residents with restraint or enablers. There were five residents requiring restraints and one resident using an enabler. The service reviews restraint as part of the quality management system.

## 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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There is a suite of infection control policies and guidelines to support practice. Information obtained through surveillance is used to determine infection control activities and education needs within the facility. Internal audits, infection control competencies and education are completed. There have been no outbreaks.

## 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)
<b>Standards</b>	0	14	0	0	3	0	0
<b>Criteria</b>	0	38	0	1	3	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy to guide practice which aligns with Right 10 of the Code. The facility manager/registered nurse leads the investigation of any concerns/complaints. Compliments and complaints are discussed at the monthly quality meetings and clinical meetings. Compliments forms are available and visible at the main entrance. There have been four internal complaints in 2019 to date. All complaints have been managed appropriately and the resolution accepted by the complainant. Residents and families interviewed were aware of the complaints process. A compliments and complaints register are maintained. There have been no DHB or HDC complaints.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The facility manager operates an open-door policy. Fifteen incident/accident forms reviewed from July 2019 identified family were notified following a resident incident. Three family members interviewed (hospital) interviewed confirmed they are notified promptly of any incidents/accidents. There is a resident advocate who is readily available and who chairs the regular resident meetings. Interpreter services are available if required. Eight residents (six rest home and two hospital) stated they are all kept well informed. Residents and family interviewed confirmed the admission process and agreement was discussed with them. They were provided with adequate information on entry.</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>WesleyCare is governed by the Christchurch Methodist Mission board. An executive director is responsible for all aspects of the mission and is supported by a Trust board of 10 members. The residential aged care service provided at WesleyCare is one of five divisions of the boards work. The Christchurch Methodist Mission has an overarching strategic plan for 2019 – 2021 that includes the mission, values and focus for the Mission. There are specific goals for WesleyCare including continuing high quality and affordable care, education and supporting the needs of Māori. There is a bicultural committee focused on reducing barriers to Māori entering residential care and strengthening relationships with Ngai Tahu. Te reo Māori classes are available to all staff.</p> <p>The facility manager of WesleyCare reports to the executive director on a monthly basis. The management team for each division (service) meet fortnightly. An operations manager (non-clinical) for the Mission commences end of September. The facility manager is supported by an acting quality manager/registered nurse who has been in the role 13 weeks and two clinical managers; however, there is a current vacancy for one clinical manager. A senior bureau RN is covering the clinical manager vacancy.</p> <p>WesleyCare provides care for up to 108 residents at hospital (geriatric and medical) and rest home level care. On the day of the audit, there were 103 residents in total – 17 residents at rest home level, and 86 at hospital level (including four younger persons with disability, one resident on end of life contract (EOL), one resident on a serious medical illness contract (SMI) and one resident on respite care).</p> <p>The service is managed by an experienced long-serving facility manager/registered nurse who is retiring in the near future. There is a succession plan in place and the facility manager will mentor and support the new manager when an appointment has been made.</p> <p>The facility manager has completed eight hours of professional development related to managing a rest home and hospital facility. She attends aged care provider forums and ARC forums. The facility manager is on the committee for the Older People Workstream working plan focusing on access and demand for residential services.</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</p>	<p>FA</p>	<p>The quality and risk management policy and procedure describe the WesleyCare home and hospital's quality improvement processes. Progress with the quality and risk management programme has been monitored through the monthly quality (health and safety/infection control) committee meeting and the clinical/facility meetings. Meeting minutes are available and evidenced discussion around quality data, trends, analysis and any corrective actions. Discussions with registered nurses and healthcare assistants (HCA) confirmed their involvement in the quality programme. Data is collected on concerns/complaints, medication, wounds/pressure injuries, accidents, incidents, infection control and restraint use. Date is entered into the electronic aged care consultant data base and benchmarked against industry standards. Internal audits have been completed as per schedule and the outcomes documented.</p> <p>Resident/relative satisfaction surveys are completed two yearly last prior to the 2018 audit and is now due again.</p>

improvement principles.		<p>The residents and relatives interviewed were very happy with the service. WesleyCare maintains a high occupancy at 97% and the vacant beds are booked for pending admissions.</p> <p>A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly by an aged care consultant who is contracted to the service. The service is currently transitioning to the consultant's electronic policies and procedures.</p> <p>There is a risk management plan in place. The Executive Director provides a health and safety report to the board on risk management and staff wellbeing. Staff have access to an employee assistance programme. All the Mission managers have attended an external health and safety programme. The health and safety coordinator for the Mission and the health and safety representative (HCA) for WesleyCare were interviewed. The WesleyCare representative attends the monthly Mission health and safety committee meeting and provides a monthly report to the quality meetings and staff meetings. Staff receive health and safety training during orientation and ongoing. Actual and potential risks are documented on the hazard register, which identifies risk ratings, controls and frequency of monitoring.</p> <p>Falls management strategies include sensor mats, and the development of specific falls management plans to meet the needs of each resident who is at risk of falling. Physiotherapy assessments and reviews are completed post falls (as requested) and six monthly as part of the care plan evaluation. Staff attend safe manual handling sessions.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident and entered into the electronic system for benchmarking. There is documented timely RN assessment for accident/incidents. Incident/accident data is linked to the organisation's quality and risk management programme and a report presented each month at the quality meeting including trending and analysis of falls (location, day of week, time of day).</p> <p>Fifteen accident/incident forms were reviewed from July 2019 including falls (witnessed and unwitnessed), stage 3 pressure injury, skin tear and one wandering. Each incident involved a resident clinical assessment and follow-up by a registered nurse. Neurological observations were conducted for unwitnessed falls and where there was an obvious knock to the head. There have been two section 31 notifications for 2019 with one stage 3 pressure injury (July) and one for RN staffing shortage (August).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</p>	PA Moderate	<p>There are human resources policies to support recruitment practices. Eight staff files reviewed (one clinical manager, one RN, one enrolled nurse, three HCAs, one diversional therapist and one team leader – laundry), contained employment contracts, references and completed orientations; however, not all files contained job descriptions and not all performance appraisals were current. Current practising certificates were sighted for the</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>RNs and allied health professionals.</p> <p>The service has an orientation programme in place. Healthcare assistants interviewed believed new staff were adequately orientated to the service on employment. There is an annual training and education programme, however the 2018 and 2019 education programme had not been completed for staff to cover all mandatory requirements in the last two years. Healthcare assistants achieve level two following orientation and completion of on-line modules. A roving Careerforce assessor is available to support HCAs to complete levels 3 and 4. On-line education (Altura) has been commenced in January 2019, but not all staff have commenced modules. Clinical staff complete competencies relevant to their role, including medication competencies, syringe driver, manual handling and wound care. Fourteen of 18 RNs including the admission nurse (RN), have completed interRAI training. RNs are supported to complete external courses.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. Residents, relatives and staff interviewed stated there were sufficient numbers of staff on duty to safely deliver residents cares.</p> <p>The facility manager and acting quality manager are full-time Monday to Friday and provide on-call. The service employs an admission RN whose role is to ensure the smooth admission of residents, undertake the first interRAI, the admission assessment and care plan and liaise with referrers and the GP. The ground floor has 58 dual-purpose beds, including eight studio units and there are 50 dual-purpose beds on the first floor. On the ground floor there are 16 rest home residents and 40 hospital level residents. On the first floor there is one rest home resident and 47 hospital residents.</p> <p>A senior bureau RN is the acting clinical manager on the ground floor and there is a permanent clinical manager on the first floor.</p> <p>Staffing for the wings are as follows:</p> <p>Ground floor rooms 17-50 (21 hospital and 12 rest home): On morning shift there is an RN and six HCAs (four full shift and two finish at 1300), on afternoon shift there is an RN and five HCAs (two finish at 2300, one at 2100, one at 2200 and one at 2000)</p> <p>Ground floor rooms 1-16 and 8 studio units (19 hospital and 4 rest home). On morning shift there is an RN and five HCAs (three full shift and two finish at 1300), on afternoon shift there is an RN and four HCAs (two finish at 2300, one at 2100 and one at 2200).</p> <p>The upstairs is divided into two 25 bed wings. Each unit has the following staffing each:</p> <p>On mornings: one RN, and five HCAs (three full shifts and two until 1300). There is one HCA on full shift that</p>

		<p>floats between the two wings.</p> <p>On afternoons: one RN and four HCAs (two full shifts, one until 2200 and one until 2200).</p> <p>Night shift there is one RN and three HCAs on each floor.</p> <p>There is the flexibility on the roster to increase hours to meet resident acuity.</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>	FA	<p>Sixteen electronic medication charts were reviewed. Medication reconciliation is completed on admission by the admissions nurse, and the registered nurses check medications on arrival from the pharmacy and report any discrepancies to the pharmacist. Medication administering follows safe medication guidelines as set down in the policies during the medication rounds observed. Medication fridge temperatures are monitored and recorded and were within expected ranges.</p> <p>All staff administering medications have completed an annual medication competency. At the time of audit there was one resident who was self-administering medications, the competencies had been completed and signed by the GP three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>WesleyCare has two kitchens. The main kitchen downstairs is large and well equipped and is where all the baking and meals are prepared and cooked. Meals are served directly to the residents in the main dining room. The second kitchen is on the upstairs level and is for washing dishes and serving meals, morning and afternoon teas. Meals are transported in hot boxes and served by the cook from the servery. Meals are plated and transported to residents in the units in hot boxes. The residents in the units are invited to dine in the dining room.</p> <p>Kitchen fridge, freezer and food temperatures are monitored and recorded, and cleaning schedules were in place.</p> <p>There is a summer and winter four-week rotational menu which has been reviewed by a dietitian. The food control plan is current.</p> <p>Special diets such as pureed meals, diabetic meals, gluten free and vegetarian meals are provided. Resident likes, and dislikes are known, and alternative foods offered. The midday meal was observed. Meals were adequate and well presented</p> <p>The chef confirmed that there are alternatives available. Any changes to nutritional requirements are communicated to the cook by the registered nurse. Additional snacks are available when the kitchen is closed.</p> <p>Feedback is gained verbally from residents on the day and through resident meetings. Residents interviewed spoke positively around the meals and food provided.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Care plans demonstrate service integration and input from allied health professionals. Care plans reviewed provided evidence of individual support and included nursing interventions for unintentional weight loss and pressure injury management. Not all resident files reviewed documented interventions to support resident needs. One resident with challenging behaviours did not have specific triggers and effective de-escalation techniques identified in the care plans and one hospital resident on SMI contract did not have a long-term care plan in place. This continues to be an area for improvement.</p> <p>Short-term care plans were in use for changes in health status, these have been reviewed and either resolved or added to the interventions in the long-term care plans. The short-term care plans reviewed documented nursing interventions. The previous finding around short-term care plans has been addressed.</p> <p>Resident files reviewed identified that family were involved as documented in the family contact sheet in resident files.</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 registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. Contact with relatives regarding resident changes was documented within the progress notes and in the family contact sheet in resident files.</p> <p>Dressing supplies were available and treatment rooms well stocked for use. The service currently has eight wounds being dressed including two pressure injuries (stage 3). A wound care specialist nurse is currently involved with a chronic pressure injury and a referral has been made to review the current cellulitis. All wounds reviewed included documented wound assessment, plans and written evaluations indicating changes and progression and deterioration of the wound. The chronic wounds were linked to the long-term care plan. The clinical manager and registered nurses were able to describe wound care and continence advice is available as needed.</p> <p>There is a suite of monitoring forms in use at WesleyCare including behaviour monitoring, vital signs and weight. Position changes, restraint and enabler monitoring are documented each shift in the progress notes.</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</p>	<p>FA</p>	<p>There are two diversional therapists, and one residents' advocate that provide an activities programme over five days each week with a weekly programme that covers all areas. There are combined activities where residents from upstairs go downstairs and vice versa.</p> <p>The programme is planned weekly, and residents receive a personal copy of planned activities. A diversional therapy plan was developed for each individual resident based on assessed needs. Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities. New initiatives recently introduced to the activities programme included school children visiting the facility and reading to the residents and visits from preschool children. The residents reported enjoyment from the pet</p>

<p>the setting of the service.</p>		<p>therapy, group games and the coloured theme days during interview.</p> <p>The service has a van and a car that is used for resident outings and appointments. Residents were observed participating in activities on the days of audit. The three-monthly resident meetings (chaired by the resident's advocate) provided a forum for feedback relating to activities. Relatives interviewed commented there was always something going on for residents to participate in.</p> <p>Activities for younger people included attending groups previously attended, and shopping trips. All residents are provided with the planner and offered to attend the activities on offer. The activities team reported a lot of the younger people enjoy the newspaper reading and the discussion group activities. When residents are on palliative care the activity team visit these residents and participate in one-on-one activities as guided by the resident.</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>Care plan evaluations were completed in the electronic system and printed in the resident files for five residents who had been in the facility for more than six months (the hospital resident on EOL contract, the respite resident, one hospital resident on ARC, and the resident on SMI contract had not been residents for six months). All long-term care plans reviewed had been updated with changes. Healthcare assistants stated the RN involved them in the review of resident care plans. The GP completes three monthly medical reviews. Progress is evaluated against the resident goals with the long-term care plan amended for any changes to care. Relatives interviewed felt they were well informed of changes and were informed of resident reviews</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>WesleyCare holds a current warrant of fitness that expires 1 January 2020. Electrical equipment is checked annually next due on 2 July 2020.</p> <p>Reactive and preventative maintenance occurs. Hot water temperatures are checked and recorded randomly on a monthly basis and were within range.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There is ceiling to floor windows in the lounge upstairs that open out to balconies. There are smaller, quieter lounges for residents and visitors. All communal areas are accessible to residents using wheelchairs.</p> <p>The well maintained outside courtyard areas are appropriate and accessible for residents using mobility aids. Seating and tables are provided, shade is provided by umbrellas and the design of the building provides sunny areas and shaded areas.</p>
<p>Standard 3.5:</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in the infection monitoring policy. A registered nurse is the designated infection control coordinator with a job</p>

<p>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>description that outlines the responsibility of the role. Monthly infection data is collected for all infections based on signs and symptoms of infection, treatment and microbiology (if available). Infection data is entered into the electronic monitoring system which is analysed and measured against industry standards for infection events. The infection control coordinator provides a monthly report on trends, analysis and any corrective actions required to the monthly quality meeting and clinical meetings. The results of surveillance and internal audits are used to identify any areas for improvement such as education and training and resources. There have been no outbreaks.</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>The service is committed to restraint minimisation, and safe practice was evidenced in the restraint policy and by interviews with clinical staff. Restraint minimisation is overseen by a restraint coordinator who is a clinical manager. There were five hospital level residents requiring restraint (three wheelchair lap belts and two wheelchair harnesses). There is evidence of alternatives to restraint considered, relative's consent and GP authorisation. One hospital resident was using a bedrail as enablers. The use of the enabler was voluntary and requested by the resident. Restraint and enabler use are reviewed three monthly. Restraint competency and education has not been completed in the last two years (link 1.2.7.5).</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	Eight staff files were reviewed, however only four files contained job descriptions that outlined the responsibility of the role for which the staff member was employed to do.	Four staff files (clinical manager, enrolled nurse, HCA and diversional therapist) did not contain job descriptions outlining the responsibilities of the role.	<p>Ensure all staff files contain signed job descriptions.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	Eight staff files were reviewed, however only three staff had performance appraisals completed within the last year. The education plan for 2018 and 2019 had not been fully completed therefore not all mandatory education had been completed by staff within the last two years.	<p>(i) Five staff files did not evidence annual performance appraisals.</p> <p>(ii) Not all mandatory education had been completed within the last two years including nutrition and hydration, pain management, falls prevention, restraint, clinical</p>	<p>(i) Ensure staff appraisals are completed annually.</p> <p>(ii) Ensure the education planner is completed and includes all mandatory</p>



			documentation, palliative care/death and dying and pressure injury prevention.	education requirements.  90 days
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>Each stage of service provision is completed by a registered nurse and is coordinated that provides a team approach, however, not all resident files reviewed had initial assessments developed within required timeframes. Residents on the age care contract (ARC) had interRAI assessments in place however, these were not always completed within required timeframes.</p>	<p>(i) One hospital resident under SMI contract did not have an initial assessment completed within 21 days of admission.</p> <p>(ii) One rest home level resident did not have a first interRAI assessment completed within 21 days of admission.</p>	<p>(i) and (ii) Ensure all residents entering long-term care have initial assessments and interRAI assessments completed within the required timeframes.</p> <p>60 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The care plans reviewed were resident-focused, promoted continuity of care and demonstrated service integration. Short-term care plans were in place for acute needs and have been either reviewed or added to the long-term care plan. However not all resident files had a long-term care plan, or all interventions documented. Staff interviewed could describe the interventions and effective strategies used for residents to provide optimum cares.</p>	<p>(i) One hospital level care resident (under SMI) did not have a long-term care plan in place.</p> <p>(ii) One rest home level resident file did not identify triggers or de-escalation techniques for episodes of challenging behaviour.</p>	<p>(i)-(ii). Ensure all residents have care plans and all interventions are documented in the care plans.</p> <p>60 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.