

# Agape Care Limited - Milton Court Rest Home

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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 BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

<b>Legal entity:</b>	Agape Care Limited
<b>Premises audited:</b>	Milton Court Rest Home
<b>Services audited:</b>	Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 16 December 2020    End date: 17 December 2020
<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>	31

# 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

Milton Court Rest Home is privately owned and operated. The rest home provides rest home and dementia level of care for up to 36 residents. On the day of the audit there were 31 residents.

Operational management is provided by the owner/manager (registered nurse) with the registered nurse providing clinical oversight. The residents and relatives interviewed spoke positively about the care and support provided.

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

The two shortfalls identified at the previous certification audit around review of policies and environment shortfalls have been addressed.

Improvements identified at this audit are required to the following: timeframes; and to updating of the dietary assessment for each resident.

## 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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Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented, and a complaints register maintained. Complaints were described as being able to be responded to in a timely manner.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Milton Court Rest Home is implementing a quality and risk management system. Key components of the quality management system include management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, review of risk and monitoring of health and safety including hazards.

Human resources policies are in place, including a documented rationale for determining staffing levels and skill mixes. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and there are staff on duty at all times to meet needs of residents in both the rest home and dementia unit. There is an implemented orientation programme that provides new staff with relevant information for safe work practice. The annual training plan is implemented.

## 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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There is an admission package available prior to or on entry to the service. A registered nurse is responsible for each stage of service provision. Resident files include medical notes by the contracted general practitioners and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. The registered nurse and caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the general practitioner.

The activities coordinators implement the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. Residents commented positively on the meals. Snacks are available at all times.

## 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 programme documented.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The service maintains a restraint-free environment. There are policies and procedures to follow if restraint or enablers are required. There were no residents using restraints or enablers during the audit and the service has maintained a restraint free environment since 2012.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. There have not been any outbreaks since the last audit.

## 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	1	1	0	0
<b>Criteria</b>	0	39	0	1	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)
<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>The following staff were interviewed as part of the audit: the owner/manager, registered nurse, two caregivers, the activities coordinator and cook.</p> <p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the owner/manager using a complaints' register. There has been one complaint in 2019 and one in 2020. The complaint in 2019 was raised by the DHB following notification by the manager. The complaint was thoroughly investigated to the satisfaction of the DHB who signed off closure of the incident. Actions were put in place to ensure that the same incident did not occur again. The complaint raised in 2020 has been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents and family members advised that they were aware of the complaint's procedure. Discussion around concerns, complaints and compliments were evident in facility meeting minutes. Concerns/complaints forms are available at the front entrance.</p> <p>The owner/manager and staff when interviewed, were aware of the right of residents and others to complain and all stated that this allowed them an opportunity to improve services.</p>
Standard 1.1.9:	FA	Management promote an open-door policy. Three relatives interviewed (two from the rest home and one from the

<p>Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>dementia unit) and six rest home residents interviewed were aware of the open-door policy and confirmed on interview that the staff and management were approachable and available.</p> <p>Residents/relatives can feedback on service delivery through three monthly resident and relative meetings and annual surveys. Meeting minutes evidenced that previous matters are discussed and closed out as concerns are resolved. Accident/incident forms reviewed evidenced that relatives had been informed promptly of any incidents/accidents; family interviewed confirmed that they were notified of any changes to resident's health status and were kept well informed.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they must pay for that is not covered by the agreement. An interpreter service is available if required.</p> <p>Information is provided around both the rest home and dementia units and models of care. The welcome pack included a pamphlet around dementia care. Family stated that they were well informed around the need for a secure unit for people with dementia. All residents and family interviewed stated that they had received information on entry to the service both verbally and in a written format.</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>Milton Court Rest Home provides rest home level of care and dementia level of care for up to 36 residents. There are 17 rest home beds and 19 dementia care beds. On the day of audit there were 15 rest home residents and 16 residents in the dementia unit. There was one resident under a younger person with a disability (YPD) contract and all other residents were under the Aged Residential agreement.</p> <p>Milton Court is privately owned and operated by the owner/manager (registered nurse with a current practicing certificate) since 2014. The second joint owner has responsibilities for the building maintenance and is the facility health and safety officer. The owner/manager is responsible for the daily operation of the business and is on site at least two days a week and as required.</p> <p>The manager is supported by a full-time registered nurse who has been at Milton Court since graduation in 2014.</p> <p>There is an annual business plan in place for 2020 which identifies the philosophy of care, mission statement, business objectives and specific aims for the service. The 2019 business goals and objectives have been reviewed.</p> <p>The manager has maintained at least eight hours annually of professional development related to managing a rest home and dementia care facility. Professional development includes attending district health board manager meetings three times a year.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>FA</p>	<p>The service has a quality risk management plan in place that is reviewed annually. The service has in place a range of policies and procedures to support service delivery that have been developed by an external consultant. These have been reviewed since the last audit and the previous shortfall identified at certification has been</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>addressed.</p> <p>The quality programme includes an annual internal audit schedule that has been implemented. Audit summaries and corrective action plans are documented where a noncompliance is identified. Issues and outcomes are reported and discussed at the staff meeting. Corrective action plans reviewed showed documentation of resolution of issues with these closed out in a timely manner.</p> <p>The staff meeting includes discussion around all aspects of the quality programme including incidents, accidents, complaints, health and safety, infection control, clinical issues, staffing, survey results and discussion of improvements. The meeting serves as a forum to review progress towards goals documented in the quality plan. Discussions with the registered nurse, the owner/manager, and staff, confirmed their involvement in the quality programme. Two staff meetings have been held during the pandemic (Covid-19), however during this time a group chat was set up with regular meetings held.</p> <p>Resident/relative meetings are usually held quarterly with one held in 2020 to date. Residents and family were kept informed through phone calls and emails at least monthly during the Covid-19 pandemic. The rest home residents interviewed confirmed that they value meetings and other forms of communication to raise issues and to discuss any improvements or suggestions. All stated that they were kept well informed of any risks or improvements, and if issues, these were resolved in a timely manner. Meeting minutes showed evidence of resolution of issues.</p> <p>There is an annual satisfaction survey for residents and relatives. The August 2020 results showed that all residents and relatives who responded were satisfied or very satisfied with the service provided. This correlates with the responses from residents and relatives interviewed during the audit.</p> <p>The service has a health and safety management system. There are implemented risk management and health and safety policies and procedures in place, including accident and hazard management. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. The service collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. The joint owner is responsible for building maintenance and is a health and safety officer who has completed level one and two of health and safety qualifications. Staff complete hazard forms for identified hazards which are reviewed by the health and safety officer. All hazard forms reviewed showed evidence of resolution of issues in a timely manner.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are</p>	<p>FA</p>	<p>As part of the risk management and health and safety framework, there is an accident/incident policy. Ten incidents from July to November 2020 were reviewed. All incident forms identified timely review by the registered nurse both of the incident and of the resident. Corrective actions to minimise resident risk were documented. Incident forms had been signed off with evidence that appropriate actions had been put in place.</p> <p>The healthcare assistants interviewed could discuss the incident reporting process. The owner/manager and registered nurse interviewed could describe situations that would require reporting to relevant authorities. There</p>

<p>systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>has been one section 31 reported to external authorities (MoH and DHB) since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are comprehensive human resources policies including recruitment, selection, orientation, and staff training and development. Five staff files were reviewed (registered nurse, three healthcare assistants and the cook) and included all appropriate documentation. Staffing levels are stable with some staff having been employed for over six years.</p> <p>A copy of practising certificates is kept on record. The owner/manager and registered nurse have a current annual practicing certificate along with other health professionals who visit the service (general practitioner, pharmacist, podiatrist, physiotherapist).</p> <p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience, and skills. Reference checks are carried out for new staff.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff noting that three have not been completed in 2020 to date because of Covid-19 pandemic. These are scheduled to be completed by January 2021.</p> <p>There was an in-service calendar for 2020 which exceeded eight hours annually for staff who attended the training offered. There has been an emphasis on staff attending online training with good attendance sighted. Completion of this is closely monitored by the registered nurse who also sits with some staff for whom English is a second language to help with understanding of the topic. There is now 100% completion of the topics that have been offered to date.</p> <p>There are 12 healthcare assistants working in the dementia care unit. Seven have completed the required dementia unit standards; two are in the process of completing the required dementia unit standards and one is enrolled. Two are newly appointed and are always placed on duty with a senior healthcare assistant who has completed the training.</p> <p>The owner/manager and the registered nurse are both interRAI trained. The registered nurse completes most of the interRAI assessments and the owner/manager is able to provide support when required or if the registered nurse is</p>

		on leave.
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The human resources policy determines 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. The registered nurse is on duty during the day Monday to Friday and shares the on-call responsibility with the owner/manager. An experienced healthcare assistant is the day supervisor who coordinates the team of healthcare assistants on duty.</p> <p>There are enough staff numbers in the rest home and the dementia care unit that meets contractual requirements. This includes two staff on each shift in the dementia unit (noting that the dementia unit is divided into two units although the door between the units is opened during the day so that residents can engage during activities) and one on each shift in the rest home. The registered nurse provides support at all times across both the rest home and dementia unit with the owner/manager also providing registered nurse support if required.</p> <p>Residents and relatives stated there were always adequate staff on duty. Staff stated they feel supported by the owner/manager and the RN who respond quickly to after-hours calls.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit. All policies and procedures had been adhered to. There are no standing orders. There are no vaccines stored on site.</p> <p>The facility uses a paper-based and blister pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. The RN and senior medication competent caregivers administer medications. All staff have up-to-date medication competencies and there has been medication education this year. The medication fridge temperature is checked daily. Eye drops are dated once opened. The ambient temperature of the medication room was not taken prior to the audit however a thermometer was purchased, and temperatures started being recorded on the day after the audit.</p> <p>Staff sign for the administration of medications on medication sheets. Ten medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use prescribed.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p>	PA Low	<p>The service has a head cook who works Tuesday to Saturday and one cook who works Sundays and Mondays. There is a kitchenhand on each day from 0700-1300 and 1600-1830. The head cook, and weekend cook have a current food safety certificate. The head cook oversees the procurement of the food and management of the kitchen.</p>

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>There is a well-equipped kitchen, and all meals are cooked on site. Meals are served in the dining rooms from bain maries. Meals going to rooms on trays have covers to keep the food warm. Special equipment such as lipped plates is available. On the first day of audit, meals were observed to be hot and well-presented and residents stated that they were enjoying their meal. The four-weekly menus were last reviewed by a dietitian in April 2019.</p> <p>There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures were monitored and recorded daily. Food temperatures are checked, and these were all within safe limits. The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes (link 1.3.3.3). This is expected to be reviewed six-monthly as part of the care plan review (link 1.3.3.3). The cook stated that they are not always informed of changes to residents' dietary needs. Special diets and likes and dislikes were noted in a folder. All residents and family members interviewed were satisfied with the meals. The food control plan is current.</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 changes the registered nurse initiates a GP consultation. Staff stated that they notify family members about any changes in their relative's health status and family interviewed confirmed this. All care plans sampled had interventions documented to meet the needs of the resident. Care plans when documented have been updated as residents' needs changed (link 1.3.3.3).</p> <p>Resident falls are reported on accident forms and written in the progress notes. Neurological observations are completed for unwitnessed falls or falls where residents hit their head.</p> <p>Care staff interviewed stated there are adequate clinical supplies and equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms are documented, and wound monitoring occurs as planned. There is currently one wound (skin tear) being treated. There are no pressure injuries.</p> <p>Electronic monitoring forms are in use as applicable such as weight, vital signs, wounds, and behaviour.</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</p>	<p>FA</p>	<p>There is an activities coordinator who provides an activities programme in the rest home for four hours a week and ten hours a week over five days in the dementia unit. The residents were observed in the dementia unit while the activities programme was being implemented and all were seen to be engaged. Poi had been made by the staff and residents and were used with music to encourage singing and exercise. The activities coordinator is newly appointed having been a cook at a previous rest home and actively engaged with residents. Caregivers also provided activities for residents. On the days of audit, rest home residents were observed going for walks, enjoying music and movement with poi used, balloon tennis and massage for one resident.</p> <p>There is a weekly programme in large print on whiteboards. The programme in the dementia unit can vary from the</p>

<p>needs, age, culture, and the setting of the service.</p>		<p>printed programme due to residents' mood and fatigue. Residents have the choice of a variety of activities in which to participate, and every effort is made to ensure activities are meaningful and tailored to residents' needs. These include exercises, games, quizzes, music and walks outside.</p> <p>Those residents who prefer to stay in their room or who need individual attention have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>Residents who wish to attend church go out with their families/friends, and Catholic volunteers come in to give communion weekly.</p> <p>Currently there are no van outings as the weather encourages residents to go out walking (or being pushed in wheelchairs) to the beach (one block away). Van outings will start again as soon as the weather changes.</p> <p>There are regular entertainers visiting the facility. Special events such as birthdays, Easter, Anzac Day, and Queen's birthday are recognised and celebrated. Residents are currently doing some Easter craft work. There is pet therapy weekly. There is community input from volunteers who come in weekly to have one-on-one chats.</p> <p>Residents have an activity assessment completed over the first few weeks following admission that describes the residents past hobbies and present interests, career, and family. Resident files reviewed identified that the activity plan is based on this assessment when this is completed. Activity plans when documented are evaluated at least six-monthly at the same time as the review of the long-term care plan (link 1.3.3.3). Residents interviewed stated that they enjoy the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Five care plans reviewed had been evaluated by the registered nurses six-monthly or when changes to care occurs if care plans are completed (link 1.3.3.3). Short-term care plans for short-term needs are evaluated and signed off as resolved or added to the long-term care plan as an ongoing problem. Activities plans are in place for four of the five residents with these evaluated six-monthly (link 1.3.7.1).</p> <p>The multidisciplinary review involves the RN, GP, and resident/family if they wish to attend. There are three monthly reviews by the GP for all residents. Family members interviewed confirmed that they are informed of any changes to the care plan.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires on 1 June 2021. There is a maintenance person who works eight hours a week over two days. They are assisted by the co-owner. Contractors are available when required.</p> <p>Electrical equipment has been tested and tagged. The scales are checked annually. Hot water temperatures have been monitored randomly in resident areas and were within the acceptable range. The rest home communal lounges, hallways and bedrooms are carpeted. The dementia communal lounges, hallways and bedrooms have</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>vinyl. Corridors are wide, have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens were well maintained. There is an enclosed secure outdoor area for each of the dementia units. All outdoor areas have seating and shade. There is safe access to all communal areas. Fencing in the dementia unit has been reinforced to ensure safety of residents. The dementia unit is at times separated by a door within the unit that is locked by a pin code (noting that if the door is locked, there is always a staff member in each 'wing'). Residents in each unit are able to access the secure outdoor garden through an external door from their unit. The shortfall identified at the previous certification audit has been addressed.</p> <p>The servery in the dementia unit now has a sliding 'door' that operates as a barrier between the kitchen and dining area. The shortfall identified at the previous certification audit has been addressed.</p> <p>Staff interviewed, stated they have adequate equipment to safely deliver care for rest home and dementia level of care residents.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (registered nurse) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection control data including trends is discussed with the owner/manager and at staff meetings. Meeting minutes are available to staff. Trends are identified, analysed and preventative measures put in place. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There are supplies of personal protective equipment and hand sanitizers for at least two weeks should an outbreak occur. Visitors are asked not to visit if unwell. Hand sanitisers are appropriately placed throughout the facility. Residents are offered the annual influenza vaccine.</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>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. The owner/manager and registered nurse both operate as the restraint coordinators. On the day of the audit there were no residents using restraints or enablers. Restraint education and challenging behaviours is included in the annual training programme and occurred in 2020 for all care staff. The service has been restraint free since 2012.</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)
Criterion 1.3.13.2 Consumers who have additional or modified nutritional requirements or special diets have these needs met.	PA Low	The residents have a nutritional profile developed on admission which identifies dietary requirements and likes and dislikes. This is expected to be reviewed six-monthly as part of the care plan review. The cook did not have a dietary profile including likes and dislikes that had been reviewed as changes occurred or six monthly and they stated that they were not always informed of changes by staff.	The nutritional profile (dietary assessment) was not updated six monthly or as changes occurred with the cook informed of changes as these occurred.	Update each resident's nutritional profile (dietary assessment) six monthly or as changes occur with the cook informed of changes.  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>The service has had a number of issues that have impacted on the registered nurse ability to complete interRAI assessments, care plans and evaluations in a timely manner. This has included responding to the pandemic (Covid-19) and health issues for a team member. The registered nurse has a plan to address the gaps and is working towards completion of documentation.</p>	<p>Assessments, care plans and evaluations are not completed in a timely manner as follows:</p> <p>(i). Four of five interRAI assessments were not completed initially or reviewed in a timely manner. (ii) Three of five initial care plans were not completed within three weeks after admission. (iii). One resident (admitted in November 2019) did not have a long-term care plan (an initial care plan and short-term care plan were being used). (iv). Four of five care plans were not reviewed in a timely manner with evaluations therefore not documented.</p>	<p>Implement the plan to ensure that assessments, care plans and evaluations are completed in a timely manner.</p> <p>90 days</p>
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## 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.