

Pacific Haven (2015) Limited - Pacific Haven Residential Care

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

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

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

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

The specifics of this audit included:

Legal entity: Pacific Haven Residential Care (2015) Limited

Premises audited: Pacific Haven Residential Care

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 8 July 2021 End date: 9 July 2021

Proposed changes to current services (if any): None.

Total beds occupied across all premises included in the audit on the first day of the audit: 29

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

Pacific Haven provides residential services for up to 30 residents requiring rest home level care. Occupancy on the day of the audit were 29 residents. The current owners (one of whom is the nurse manager) have owned the service since 2015 and they own another facility elsewhere.

Pacific Haven is managed by a facility manager with support by an operational manager and clinical nurse manager (registered nurse) who both commenced in their roles May 2021.

This unannounced surveillance audit was conducted against a subset of the 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 general practitioner.

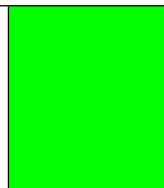
Residents, relatives and the general practitioner interviewed, praised the service for the support provided. The owners continue to make improvements to the environment. Environmental improvements include ongoing refurbishment and painting of bedrooms.

The shortfall from the previous audit related to quality information at meetings has been addressed.

This audit identified shortfalls around management of adverse events, integrated records and completion of progress notes.

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.

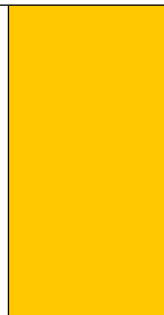


Standards applicable to this service fully attained.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

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.

Pacific Haven has policies and procedures in place which support residents at rest home level needs. A documented quality and risk management programme is implemented. There is a current business plan that includes specific goals for 2021.

Organisational performance is monitored through several processes to ensure it aligns with the identified values, scope and strategic direction.

Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Staff receive ongoing training and there is a training plan developed and commenced for 2021. Rosters and interviews indicated sufficient staff who are appropriately skilled with flexibility of staffing around resident's' needs.

An annual resident/relative satisfaction survey is completed and there are regular resident meetings, memo`s and newsletters. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported and followed through.

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.
--	--	--

Prior to entry to the service, residents are screened and approved. The registered nurse (clinical nurse manager) is responsible for each stage of service provision. The registered nurse assesses and reviews residents' needs when health changes against outcomes and goals.

Residents interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. The programme includes community visitors, outings and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for the residents.

Medication policies reflect legislative requirements and guidelines. The service uses an electronic medication system. Staff who are responsible for the administration of medicines, complete annual education and medication competencies. The general practitioner reviews medications three-monthly.

All meals are prepared on-site. Individual and special dietary needs are catered for and alternative options are available for residents with dislikes. A dietitian has reviewed the menu. Residents interviewed responded that their likes and dislikes are catered for.

An activities coordinator implements the activity programme for the residents. Residents and families reported satisfaction with the activities programme.

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.
--	--	--

The building has a current building warrant of fitness which expires 1 April 2022. Equipment has been checked and calibrated. Essential contractors are available 24-hours. There is a preventative maintenance schedule. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and courtyards on the ground floor. Seating and shade are provided.

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.
---	--	--

Pacific Haven has a restraint minimisation and enabler use policy in place which reflects safe practice and procedures. There has been no restraint or enablers used at Pacific Haven since 2015. Staff receive training around restraint minimisation, and challenging behaviour management.

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.
---	--	--

There is a monthly surveillance programme where infections are collated, analysed and trended with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings and management quality meetings. Evidence is seen of education and staff involvement with any infections that are identified during the surveillance programme.

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	14	0	1	2	0	0
Criteria	0	39	0	1	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>A complaints policy and procedures have been implemented, residents and their family/whānau are provided with information on admission. Complaint forms are available at the entrance to the facility and are easy to find. A complaint register is maintained. The service had one complaint in July 2019 which the complainant also copied to the Health and Disability commissioner and the DHB. The complaint was closed off in July 2020 by the Health and Disability commissioner with no identified issues in respect of the complaint. There was one complaint made in 2020 year to date and was reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up conversations, resolution and demonstrates that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner (HDC).</p> <p>During interview with residents, a relative and staff (four care givers, one cook, one housekeeper) all reported their understanding of the complaints process. Staff confirmed that complaints are discussed with them, and they notify the RN and/or the management if any residents or relatives want to make a complaint.</p>
Standard 1.1.9: Communication Service providers communicate	FA	<p>The relative interviewed (one relative) stated they are informed of changes in health status and incidents/accidents. This was consistently confirmed on incident forms reviewed where relatives wished to be contacted. Where next of kin /relatives are not involved in the resident's care journey, this was recorded on the form.</p> <p>Residents (five ,including: one funded through the long-term chronic health contract and one younger persons with a</p>

effectively with consumers and provide an environment conducive to effective communication.		disability) stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur monthly, and the management have an open-door policy. Residents and relatives are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family).
<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>	FA	<p>Pacific Haven provides residential services for people requiring rest home level care and can accommodate up to 30 residents. On the day of the audit, there were 29 residents (including one boarder). Twenty-two are under the aged residential care contract, five are funded through the long-term chronic condition's contracts (LTS-CHC), one is funded through the younger person with disability (YPD) contract.</p> <p>The organisation consists of two directors who own the business. They have previous experience in aged care. One director operates as a full time non-clinical manager across two facilities and the other, the nurse manager- a registered nurse, provides clinical support. Both have attended in excess of the eight hours education required including leadership and management training. The day-to-day operation of Pacific Haven is the responsibility of the operational manager (non-clinical) whom reports and is overseen by the facility manager who continues to run the facility. She is fully orientated to her role and has future planned training related to her role. She is supported by a full-time clinical nurse manager (the registered nurse). Staff spoke positively about the support/direction and management of the current management team.</p> <p>The goals and direction of the service are well documented in the 2021-2013 business plan and the progress toward previous goals has been documented and are discussed at the management meetings.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>A suite of policies and procedures are current and are updated(May 2021) and reviewed regularly in line with best practice and current legislation. Internal audits are completed as per the internal audit schedule. Any area of non-compliance includes the implementation of a corrective action plan with sign-off by the nurse manager when it is completed.</p> <p>A caregiver is the health and safety officer and is supported by the operational manager. The health and safety committee comprise of the managers, a care giver, maintenance person, housekeeper and cook. Pacific Haven collects information on resident incidents and accidents as well as staff incidents/accidents and provides follow-up where required. Hazards are identified on hazard identification forms. The hazard register is relevant to the service and has been regularly reviewed and updated in June 2021.</p> <p>There are monthly management/quality meetings which include discussions on aspects of quality and risk including the monthly infection control and incident/ accident statistics, all of the quality data is shared with the staff at monthly meetings. This is an improvement from the previous audit and the shortfall identified had been addressed.</p>

		<p>Resident meetings are held three-monthly. Pacific Haven are proactive in providing consultation with residents/relatives and staff through the monthly newsletters.</p> <p>The 2019 resident satisfaction survey had a 90% response rate and identified 100% satisfaction with staff interactions. The 2020 resident satisfaction survey had an overall satisfaction rate of 85% and 80% satisfaction rate with activities provided. Corrective actions have been implemented around interventions to motivate and encourage residents to be more motivated in attending activities. The resident meeting minutes and resident interviews evidenced general satisfaction around activities provided.</p> <p>The residents' food satisfaction survey for 2020 identified 100% satisfaction with breakfasts and overall satisfaction with the current menu and alternatives available.</p> <p>The operational manager and clinical manager interviewed stated residents are actively supported to re-establish family relationships. Residents/relatives were informed of the survey results in a newsletter and at the three-monthly resident/relative meeting.</p> <p>Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls (link 1.2.4.3).</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>	<p>PA Moderate</p>	<p>Pacific Haven documents and analyses incidents/accidents, unplanned or untoward events, and provides feedback to the service and staff so that improvements are made. Individual adverse event reports are completed for each incident/accident with immediate action noted and any follow-up action required. Minutes of the management/quality meetings, and staff meetings reflected discussions have occurred around minimising risks. A monthly data sheet is completed indicating all incidents/adverse events and preventative measures in place to minimise risks.</p> <p>Ten adverse event forms were reviewed. Where unwitnessed falls occurred, neurological observations were commenced and completed. All but two adverse event forms demonstrated that there was clinical follow-up by the nurse manager.</p> <p>A section 31 form was completed in April 2021 for unaccounted medication as well as an incident form.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p>	<p>FA</p>	<p>There is a comprehensive staff recruitment policy to guide management to ensure that the most appropriate people are recruited to vacant positions.</p> <p>Five staff files reviewed (the registered nurse, a recently employed caregiver, one long-standing caregiver, the</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>activities coordinator, one cook/kitchenhand). All had relevant documentation relating to employment, and relevant checks were completed to validate individual qualifications and experience. Of the files reviewed, a performance appraisal occurred annually for long-standing staff.</p> <p>Current annual practicing certificates are kept on file. There is a minimum of one care staff member with a current first aid certificate on every shift.</p> <p>The orientation package provides information and skills around working with residents with aged care and mental health related needs (a proportion of residents have mental health issues) and was completed in all staff files sampled. The evaluation section in the orientation package had been completed and signed off in a timely manner. Staff completed training in August 2020 related to management of behaviour related to addictions.</p> <p>There is an annual training plan in place that is being implemented, with additional training sessions added as required. Staff have competencies for medications including insulin administration as well as infection control, manual handling, hand washing, emergency management, and wound care. All staff attended training on dealing with addiction that was provided by Odyssey House. Following the introduction of the additional training for caregivers, staff reported increased in their confidence in dealing with residents' challenging behaviour.</p> <p>Pacific Haven encourages staff to complete Careerforce training. There are eight caregivers in total and one enrolled nurse to cover the roster. Currently there are two staff who completed level 2 and two completed level 3 Health and Wellbeing with a further four are enrolled in level 2. The clinical nurse manager is interRAI trained.</p> <p>The operational manager is overseeing the activities (was previously the activities coordinator for three years) while the new activities coordinator is inducted to the new role. Kitchen staff all completed food safety training.</p> <p>Residents and one relative interviewed stated that staff were knowledgeable and skilled.</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>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. Staffing rosters were sighted and there were staff on duty to match needs of different shifts and needs of different individual residents.</p> <p>The clinical nurse manager works 40 hours a week across Monday to Fridays each week. The enrolled nurse works Friday- Sundays pm shift (3.30 pm -11pm)</p> <p>There are two caregivers on the morning shift: 1x 7 am to 2pm and 1 x 9 am to 3 pm.</p> <p>The afternoon shift has two caregivers 1 x 2.30 pm to 8.30 pm and one from 4 pm to 10.30 pm.</p> <p>Nightshift has one caregiver from 10.30 pm to 7 am.</p> <p>The owner (clinical) and clinical nurse manager live close to the facility and are on call 24/7.</p>

		<p>The activities coordinator works 1 pm -3.30pm Mondays to Fridays.</p> <p>There are designated food services staff, housekeeping staff seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>Progress notes in the resident file are maintained by caregivers and the enrolled nurse. Residents have individual files where the care staff made entries in progress notes. The clinical nurse manager had a separate folder divided into A-Z with all residents` GP notes filed and the registered nurse progress notes. This file is kept in the clinical nurse managers locked office, so when the care staff look at the file, they cannot see RN entries or GP review/instructions.</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>There are policies and procedures in place for safe medicine management that meet legislative requirements. Caregivers, enrolled nurse and the clinical nurse manager who administer medications have completed a practical and written medication competency. The pharmacist had undertaken an audit following a notification of unaccounted controlled medication (link 1.2.4). These formed the basis of a corrective action plan which had essentially been completed (one action was an education session for medication administering staff the week following audit). The pharmacist provides annual in-service on medication administration and medication management and education on an annual basis. Medications were checked on delivery against the medication chart by the RN, as evidenced by RN signature on the blister packs and electronic system. Standing orders are not used. There was one resident self-medicating (inhalers), and the appropriate documentation was completed as required. All medications are stored safely. The medication fridge and room temperature are monitored. All eye drops were dated on opening.</p> <p>Ten medication charts reviewed had photo identification and an allergy status on the medication chart. The GP had reviewed the medication charts at least three-monthly. The electronic medication administration system identified all prescribed medications had been administered as prescribed and `as required` medication has an effect recorded on the system and in the progress notes. Fridge and room temperatures were recorded regularly and within set parameters.</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>All meals at Pacific Haven are prepared and cooked on site. The qualified chef works Monday, Tuesdays 9.30am to 3.30 pm and Wednesday to Fridays from 10.30-1pm . The chef is supported by a weekend cook who works who works 9.30 am to 3.30pm. This cook has chemical and food safety training and completed units 167 and 168. . There is a five weekly seasonal menu, which had been reviewed by a dietitian (June 2021).</p> <p>The food control plan is due to expire April 2022. Meals are served directly from the kitchen to residents in the adjacent dining room. Dietary needs are known with individual likes and dislikes accommodated. Dietary requirements, cultural and religious food preferences are met. Additional or modified foods such as pureed foods and diabetic desserts are provided as required. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p> <p>Fridge, freezer and end-cooked temperatures are monitored and recorded. Containers of food are labelled and dated. All perishable goods in fridges are date labelled. The dishwasher is checked regularly by a contracted service. A cleaning schedule is maintained.</p> <p>All food services staff have completed training in food safety and hygiene and chemical safety. Nutrition and safe food management policies define the requirements for all aspects of food safety.</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>	FA	<p>When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. There was evidence that family members were notified (where involved and agreed by the resident) of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. All files reviewed evidence family involvement. Resident, clinical nurse manager and operational manager interviews confirmed a low level of family involvement by choice . Where families are involved, notifications were documented in the resident files as agreed.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A register of wounds is maintained. A wound management plan, dressing application record and evaluation notes were in place for all wounds. One resident had a current wound: a laceration following a mobility scooter accident.</p> <p>There are recorded interventions for challenging behaviour, management of diabetes, acute pain and excessive smoking and drinking habits.</p> <p>Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified.</p> <p>Short term care plans are used for acute health issues including, chest infection, wound management and is signed off as resolved or transferred to the long-term care plan.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain and challenging behaviours.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A new activities coordinator/caregiver works Monday to Fridays and provides activities between 1pm and 3.30pm. She is supported by the operations manager who previously held this role.</p> <p>The activities programme is varied, flexible and age appropriate. Activities include weekly movies, shopping, mystery drives and out to a food chain. Activities provided are appropriate to the needs, age and culture of the residents. The activities are meaningful and include (but are not limited to), adult colouring, arts, newspaper reading (a volunteer), walks, music and word games. Activities are often spontaneous and the programme flexible to meet the residents' preferences. Community links and social interaction is maintained through community groups. There is an interdenominational church service held six-weekly on the weekend. A three-monthly resident meeting is held where activities are discussed.</p> <p>A resident diversional therapy profile is completed on admission. Each resident has an individual activity plan however three of the five files reviewed did not have a recent evaluated and updated diversional therapy plan in place. There was evidence of help being given to residents to follow up their individual interests both within and outside the facility. On the day of the audit seven residents were observe signing out leaving individually to the shops, mall or to get on a bus.</p> <p>Families are invited to the monthly resident meetings and events. The operational manager and residents interviewed confirm family attendance and visiting is exceptionally low. The service receives feedback on activities through one-on-one feedback, resident meetings and surveys.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans reviewed were evaluated by the nurse manager and/or RN within three weeks of admission and a long-term care plan developed. Person-centred care plans had been evaluated six-monthly. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented (link 1.3.3.4).</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	FA	<p>The building has a current building warrant of fitness which expires 1 April 2022. Equipment has been checked and calibrated. Essential contractors are available 24-hours. There is a preventative maintenance schedule. A maintenance book is maintained and checked regularly throughout the day. Hot water temperatures are checked randomly in resident rooms and main kitchen monthly. All temperatures are within range. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is safe access to the outdoor areas and courtyards on the ground floor. Seating and shade are provided.</p>

environment and facilities that are fit for their purpose.		
<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>	FA	<p>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The registered nurse (clinical nurse manager) is the designated infection control person. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly summary and then analysed and reported to staff meetings as sighted in staff meeting minutes for 2020 and 2021. There is a comprehensive Covid- 19 organisational policy. The clinical nurse manager interviewed stated that all staff and residents have received Covid 19 vaccinations and flu vaccinations are booked.</p> <p>There was clear communication (sighted) in staff meeting minutes, residents meeting minutes, newsletters and resident memos regarding the risk and information during Covid -19 risk periods. Visitors completes a health declaration and register for Covid-19 tracing requirements.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service philosophy includes that restraint is only used as a last resort. There were no residents at the time of the audit using restraint or enablers. The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. The education plan includes restraint education, and education sessions have been held on management of challenging behaviours. Staff interviewed clearly identified the difference between enablers and restraint. There had been no residents using restraint or enablers since 2015.</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 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	PA Moderate	Ten adverse event forms were reviewed. An analysis of incident forms is completed monthly, and trends are identified. Following an unwitnessed fall neurological observation monitoring was completed, entered in the progress notes, with timely follow up by a registered nurse documented. Two of five files reviewed had no incident report form completed for an adverse event that was described in the progress notes. There were two (of ten) adverse event forms not signed off by the registered nurse.	The following shortfalls were identified: (i). One resident (rest home) had a progress entry made by a caregiver stated` fallen over a few times`. No incident report form was completed for any adverse event on the day. (ii) One resident (LTS-CHC) had a choking incident recorded in the progress notes. The dietary profiles were changed following a nutritional assessment by the registered nurse; however, no incident report form was completed for the event. (iii). The adverse event form for a bruise (April) and skin tear (May) were not signed off by a registered nurse however, a short-term care plan was commenced for each.	(i)-(iii). Ensure adverse events forms are completed for each event, followed up and signed off by the registered nurse and also addressed in the progress notes. 60 days
Criterion 1.2.9.10	PA Low	Progress notes in the resident file are	Resident notes are not all integrated.	Ensure all

All records pertaining to individual consumer service delivery are integrated.		maintained by caregivers and the enrolled nurse. Residents have individual files where the care staff made entries in progress notes. The clinical nurse manager had a separate folder divided into A-Z with all residents' GP notes filed and the registered nurse progress notes. This file is kept in the clinical nurse managers locked office, so when the care staff look at the file, they cannot see RN entries or GP review/instructions.		resident notes are integrated 90 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Moderate	There is a verbal and written handover between shifts. Progress notes are not integrated (link 1.2.9.10). The RN documents registered nurse input to care, post incident form follow up, and RN oversight on an evaluation form rather than the required controlled documents as per policy.	(i)There are inconsistent entries in the progress notes by the registered nurse . (ii). The incorrect document is used to document registered nurse resident input, clinical oversight and follow up after adverse events.	<p>(I) Ensure resident records include regular registered nurse input/assessment and evaluation. (iii). Ensure records are documented on the correct form as per policy.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.