

# Elms Court Lifecare Limited - Elms Court Lifecare

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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:

**Legal entity:** Elms Court Lifecare Limited

**Premises audited:** Elms Court Lifecare

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 10 November 2021 End date: 11 November 2021

**Proposed changes to current services (if any):** The service proposed to add residential disability services (YPD) to their certificate. This surveillance audit verified that the service is suitable to provide the level of care required.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 30



# 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
	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

Elms Court Lifecare is privately owned and operated since January 2019. The service provides care for up to 32 rest home and hospital (geriatric and medical) level care residents. At the time of the audit there were 30 residents in total.

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

The manager is a registered nurse, and she is supported by the owner/director and administrator. Residents and relatives interviewed were complimentary about the care and services provided.

The shortfall at the previous audit relating to interventions remains an area for improvement.

This surveillance audit identified a further improvement required relating to evaluation of short-term care plans.

## 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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Discussions with families identified that they are informed of changes in their family member's health status. There are regular resident meetings where residents can provide feedback on all services. Complaint's policies and procedures meet requirements and residents, and families are aware of the complaints process. Complaints are managed appropriately and timely.

## 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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Services are planned, coordinated, and are appropriate to the needs of the residents. Quality and risk management processes are established. Quality goals are documented for the service. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Staff documents adverse, unplanned, and untoward events. The health and safety programme meets current legislative requirements.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The manager is a registered nurse and is supported by the owner/director. The manager is on site five days a week and is on call when required. They are supported by a stable workforce including a team of RNs.

There are adequate numbers of staff on duty to ensure residents are safely cared for. The residents' files are appropriate to the service type.

## 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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The service has assessment processes and residents' needs are assessed prior to entry. Registered nurses are responsible for all stages of service provision. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans are completed and included allied health professional involvement in resident care.

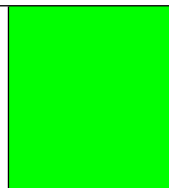
The lifestyle coordinator implements the activity programme to meet the individual needs, preferences, and abilities of the residents. Community links are maintained where possible within the Covid-19 risk management strategies. There are a variety of activities that are meaningful to the residents.

There are medicine management policies in place that meet legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. Electronic medication charts have photo identification and allergy status noted. Medication charts are reviewed three-monthly by the general practitioner.

All food and baking is done on site. The menu has been reviewed by a dietitian. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

## 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 holds a current warrant of fitness and approved fire evacuation scheme. There is a reactive maintenance system and planned maintenance schedule in place. There has been upgrades made to the kitchen including new equipment.

## 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.

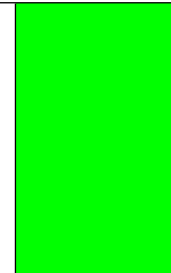


Standards applicable to this service fully attained.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. During the audit there were three residents using an enabler (four enablers in use) and no restraints were in use.

## Infection prevention and control

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



Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The registered nurse is the infection control coordinator. A suite of infection control policies and guidelines meet infection control standards. Staff receive annual infection control education. Surveillance data is collected and collated. Covid -19 prevention strategies are implemented to manage risk.



## 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 service has a complaints policy that describes the management of complaints process. There are complaint forms available and the complaints policy is displayed at the service entrance. Information about complaints is provided on admission. Interviews with residents and relatives confirmed an understanding of the complaints process. There have been no complaints made in 2020 and three in 2021. The complaints were identified as low risk and were managed appropriately with acknowledgement, investigations and responses recorded. Family members stated they have had no concerns to report and were happy with the care and service provided. Discussions with residents and families/whānau confirmed that they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p> <p>There have not been any complaints lodged with the service from external authorities.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is a policy around open disclosure which is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The care staff (three caregivers, one RN, one lifestyle coordinator) interviewed, understood about open disclosure, and providing appropriate information when required.</p> <p>Two relatives (hospital) interviewed said they are kept informed of the resident's status, including any events adversely affecting the resident. Ten accident/incident forms reviewed reflected documented evidence of families</p>

<p>provide an environment conducive to effective communication.</p>		<p>being informed following an adverse event. Two rest home and two hospital level residents (both younger persons with disabilities) were interviewed, and all confirmed they receive appropriate communication through resident meetings and can address their concerns openly. One family member confirmed they were supported to have a family meeting through an online platform with the GP. The two younger persons interviewed confirmed they receive adequate information through resident meetings, general discussions with staff and access to the internet.</p> <p>An interpreter service is available and accessible if required through the district health board. There were no residents at the facility who were unable to speak or understand basic English.</p> <p>Family members interviewed confirm they are updated with any changes in health of their relative and feel informed about the facility's strategy under the Covid 19 preparedness framework.</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>Elms Court Lifecare provides rest home and hospital (geriatric and medical) levels of care for up to 32 residents. On the day of the audit there were 30 residents. This included: five residents at rest home level care including one resident funded through severe medical condition (SMI) contract. There were also 25 residents at hospital level care including one ACC, five younger persons with disability funded by the ministry of health on a disability support contract (YPD) and one on individual funding respite care (IF) waiting for transfer to a hospital YPD contract. All beds are certified as dual-purpose beds. The service will soon have more than five YPD residents and proposed to add Ministry of Health funded younger persons disability contract (YPD) to their certificate. This has been identified in this audit in changes to the service and this audit verified that residents identified as YPD were able to be supported by the service.</p> <p>A philosophy, mission, vision, and values are in place. The business plan (2021) was reviewed in July 2021 by the manager and owner of the facility. The business plan includes quality goals including health and safety and clinical goals.</p> <p>The owner/director has owned the service since the beginning of 2019. The manager is a registered nurse (was previously the clinical manager till May 2021) and has previous management experience. The manager maintained a minimum of eight hours of professional development per year relating to the management of an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	<p>FA</p>	<p>A quality and risk management system is understood and being implemented as confirmed during interviews with the manager and staff.</p> <p>Policies and procedures align with current good practice and meet legislative requirements. Policies have been reviewed in May 2021, modified (where appropriate) and implemented. Reviews take place two yearly or when policies are updated. A document review schedule is in place. New policies are discussed with staff.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>reporting, staff education, infection control data collection and complaints management. Data is collected for a range of adverse event data (e.g., skin tears, falls, infections) and is collated and analysed monthly for trends. An internal audit programme is being implemented. Quality data and outcomes are discussed with staff in the two monthly staff and quality meetings. Two monthly resident meetings are completed and are also open to families to attend.</p> <p>A risk management plan is in place. Health and safety policies reflect current legislative requirements. Actual and potential risks are documented on a hazard register, which identifies risk ratings and documents actions to eliminate or minimise each risk. A plan is implemented to orientate contractors to the facility's health and safety programme. The hazard register had been reviewed in June 2021. The health and safety representative (caregiver) has been in the role for more than two years and has completed relevant training.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling. This includes (but is not limited to) sensor mats, post fall assessments, implementation of exercise programme prescribed by a physiotherapist, specialised care plans and additional training for staff.</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>FA</p>	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. Incident/accident data is linked to the service's quality and risk management programme. Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by an RN. Neurological observations are conducted for suspected head injuries and when unwitnessed falls occurred. The shortfall identified at the previous audit related to the completion of neurological observations had been addressed.</p> <p>The manager is aware of statutory responsibilities in regard to essential notification with no essential notification required since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>FA</p>	<p>Human resources policies are in place, including recruitment, selection, orientation and staff training and development. Five staff files reviewed (two caregivers, two RNs, one lifestyle coordinator) included evidence of the recruitment process, including reference checking, signed employment contracts and job descriptions, and completed orientation programmes. The orientation programme provides new staff with relevant information for safe</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>work practice. Staff interviewed stated that new staff were adequately orientated to the service.</p> <p>An education and training programme is provided for staff that meets contractual obligations. In-service training is offered to staff in two blocks each year. Each block is repeated twice to enable as many staff as possible to attend. Education documentation reviewed, included all compulsory subjects, and had a high attendance rate (100% of staff). Additional training was evidenced through meetings and ad hoc training. The service introduced online training in May 2021 to supplement education opportunities.</p> <p>Competencies are completed specific to worker type and include medication, manual handling, and restraint competencies annually. Individual training and competency records are available on each staff file. A register of current practising certificates for health professionals is maintained. All registered nurses have a current first aid certificate and syringe driver competency on file. Nine of nine RNs, including the manager, have completed their interRAI training. Registered nurses and caregivers have received ongoing training that relates to the provision of hospital (medical) level of care including palliative care, falls management and manual handling techniques. Training is provided by nurse specialists for a range of clinical issues including management of Parkinson's, Multiple sclerosis, swallowing difficulties, catheter changes and tracheostomy care. Staff interviewed confirmed they have received education around clinical issues related to younger persons with disabilities and include communication needs, mobility, and nutritional needs. Registered nurses have recently completed formal external palliative care training.</p> <p>Training records demonstrated that when a resident is admitted with a care need that is not familiar to staff, immediate training is given in brief form, prior to or at the time of admission.</p> <p>Staff confirmed they have access to Careerforce training to support them to complete the certificate in health and wellbeing. There are 22 caregivers and nine have completed NZQA level 3 and 4 certificates. Caregivers interviewed confirmed they are supported with enrolment to complete formal qualifications.</p> <p>Staff are required to be double vaccinated against Covid 19 to continue employment. Education sessions include Covid preparedness and drills, using of PPE and isolation precautions.</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</p>	<p>FA</p>	<p>The staffing policy aligns with contractual requirements. The manager and clinical manager are on site five days a week and available on call. Care partners interviewed stated that the management and registered nurses were supportive and available to them.</p> <p>On the days of audit there were 30 residents (5 rest home and 25 hospital).</p> <p>There is an RN on duty for each shift seven days a week.</p> <p>For care partners the staffing is: AM - two long shifts and two short shifts. PM - two long shifts and two shorter shifts (5 pm-10 pm) and one caregiver at night.</p>

<p>service providers.</p>		<p>Two lifestyle coordinators are rostered seven days a week from 9 am to 4.30 pm. There is also a physiotherapy assistant Monday to Wednesday. There are housekeeping, maintenance and kitchen staff.</p> <p>Interviews with residents and families confirmed staffing overall was satisfactory. Residents interviewed confirmed call bells are responded to in a timely manner. The roster evidenced to have experienced caregivers on each shift.</p> <p>Caregivers interviewed confirmed the lifestyle coordinator (caregiver), manager (RN) and the RNs allocated on the shifts assist the caregivers with cares when required.</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>	<p>FA</p>	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. Registered nurses administer medications and caregivers are competent as second checkers. Medication education and medication competencies have been completed annually. All medications are stored safely.</p> <p>The service uses a four-weekly robotic roll system for regular medications and blister packs for 'as required' medications. All medications delivered are checked against the electronic medication charts and recorded in the resident medication chart when checked in. There were no self-medicating residents on the day of audit. The medication fridge is monitored daily and maintained within the acceptable temperature range. The medication room air temperatures are taken and recorded daily. All eye drops were dated on opening. There are nurse initiating standing orders for non-prescription medicine that comply with all key requirements of the Medicines (Standing Order) Regulations.</p> <p>Ten medication charts on the electronic system reviewed met legislative requirements. All residents have individual medication orders with photo identification and allergy status documented. Medications had been signed as administered in line with prescription charts. Medication administration was observed to be compliant with policy and practice. 'As required' medications had indications for the medications recorded and effectiveness of pain medications. Nutritional supplements are charted on the electronic medication chart and administered and signed for.</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</p>	<p>FA</p>	<p>There is a kitchen manager (qualified chef and baker) supported by morning and afternoon kitchenhands and a weekend cook. The kitchen manager has been in the role for twelve months but has extensive aged care experience.</p> <p>There is a food services policy and procedure manual. The food control plan expires 18 February 2022. Food services staff have completed food safety and hygiene training. All meals are cooked on site by cooks who are supported by morning and afternoon kitchenhands. The four weekly seasonal menu has been reviewed by a dietitian in October 2021. The cook receives a dietary profile for each resident and is informed of any changes in dietary requirements. Resident dislikes and food allergies are accommodated. Soft/pureed meals, vegan and</p>

<p>service is a component of service delivery.</p>		<p>gluten free diets are provided. Meals are held in a bain marie until served directly to residents in the adjacent dining room. Meals to residents in rooms are plated and kept hot with insulated lids. Specialised utensils and lip plates are available as required.</p> <p>Lunch was observed in the dining room and there was enough support available from staff to assist and supervise residents.</p> <p>Perishable foods in the chiller and refrigerators are date-labelled and stored correctly. Fridge and freezer temperatures are monitored and recorded. End-cooked temperatures are taken and recorded on all meals. Chilled inward goods have temperatures recorded on delivery. The chemical provider checks the dishwasher for effectiveness. Chemicals are stored safely in the kitchen. The cleaning schedule is maintained.</p> <p>Residents have the opportunity to feedback on food services through resident meetings and surveys. Residents and family interviewed were complimentary about the food service and quality of food.</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>PA Moderate</p>	<p>When a resident's condition alters, the RN initiates a review and if required a GP review. There is documented evidence on the family contact forms in each resident file, that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. The RNs interviewed can initiate referrals to specialists such as speech and language therapists, wound care specialists, and the palliative nurse. The GP initiates medical referrals. One resident with behaviours of concern had de-escalation techniques included in the care plan and had a monitoring chart completed. Family members interviewed confirmed care delivery and support by staff is consistent with their expectations.</p> <p>Five care plans were reviewed and did not always reflect detailed interventions needed to support all the needs of the resident. The shortfall identified at the previous audit around interventions has not been addressed.</p> <p>Wound management policies and procedures are in place. A wound assessment and short-term care plan and wound dressing application record and evaluations were in place for two wounds (skin tears). Wounds had been evaluated at the documented frequency. There were no current pressure injuries and evidence of a resolved stage two pressure injury. There was adequate pressure relieving equipment available and staff had received education around the prevention of pressure injuries and skin management. A wound specialist is available for support and advice. The morning registered nurse is the wound champion and has completed formal training in pressure injury and wound management.</p> <p>Adequate dressing supplies were sighted, and continence products are available. The residents' files included a urinary continence assessment, bowel management plan, and continence products used.</p> <p>Monitoring occurs for food and fluids, pain, turning charts, weight, blood glucose, enabler monitoring and challenging behaviours and neurological observations had been completed for all unwitnessed falls. The electronic medication system is well utilised for the recording of weights, blood pressure, vital signs blood glucose and the GP</p>

		notes are also entered into the system.
<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>The service employs a lifestyle coordinator who is currently progressing through the diversional therapy qualifications. She works Tuesday to Saturday from 9 am to 4.30 pm. She is supported by the physiotherapy assistant for the exercise programme and a second part time lifestyle coordinator (Sunday and Monday 9 am to 4.30 pm). The monthly programme is developed in consultation with residents and reflects their interests and abilities. The integrated programme is varied and provides group and individual activities to meet the hospital and rest home, and younger people with disabilities' recreational preferences and interests. There are activities planned seven days a week.</p> <p>One-on-one contact is made with residents daily, who are unable to or choose not to participate in group activities. Individual activities include hand massage, chats, reading etc. Room visits are made daily to residents, ensuring they are aware of the activities being offered. Activities include (but are not limited to); daily exercises, newspaper reading, hand massages, quizzes, board games, music, art and crafts, bowls, mini golf, movies, walks and gardening. Community visitors include church visitors and entertainers, kapa haka group, pre-school, school children and girls brigade groups. Community groups had not been to the facility in the last eight months due to Covid-19 restrictions and risk management.</p> <p>The service has a wheelchair hoist van and there are weekly outings to community events such as performances, concerts, shopping, cafés, lunches, and inter-home visits to Elms Court rest home. There are scenic drives and picnics. Themes and festivities are celebrated.</p> <p>Residents have a social profile and interests and hobbies form completed over the first few weeks after admission, which forms the basis of an activities plan, which is then reviewed six-monthly. A record is kept of individual resident's activities and monthly progress notes are documented. Resident and relative meetings are held two monthly which provides an opportunity for residents and relatives to feedback on the service and the activities programme. Residents and relatives interviewed commented positively on the activity programme. The younger persons interviewed confirmed they are supported to maintain their community links and special interests and are provided access and transport to continue their normal routines. On the day of the audit younger persons with disabilities were observed to engage within a group with various craft activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	PA Low	<p>Five long-term care plans were reviewed. There are written evaluations that identify if the resident goals have been met or unmet. There are three-monthly clinical reviews by the medical practitioner or sooner if needs change. Short-term care plan evaluations are completed for wounds, infections, and other short-term conditions, however not always signed off as resolved. Evaluations are conducted by the RNs with input from the resident, family, lifestyle coordinator, caregivers, and GP. Family are notified of any changes in the resident's condition, as</p>



comprehensive and timely manner.		evidenced in resident files reviewed and confirmed in family interviews.
<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>	FA	<p>There is a current building warrant of fitness that expires 1 June 2022. A maintenance person addresses day-to-day repairs and completes planned maintenance. There is a scheduled maintenance plan in place that includes internal and external maintenance, testing and tagging of electrical equipment and calibration/functional checks of resident related equipment. Hot water temperatures in resident areas are monitored monthly and are below 45 degrees Celsius.</p> <p>There has been upgrades made to the kitchen including new kitchen equipment. The dining room is spacious to accommodate power chairs, wheelchairs, and other mobility equipment.</p> <p>The building is a single level building with easy access to the garden. Communal areas are spacious and comfortable for the residents. There are external gardens and seating available with shade for residents. The facility has sufficiently wide corridors with handrails for residents to safely mobilise using mobility aids including power chairs. Residents were observed moving freely around the areas with mobility aids where required.</p> <p>The caregivers interviewed stated there was sufficient equipment (hoists, pressure relieving devices and weight scales) to safely carry out the cares as documented in care plans.</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>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used, however not always evaluated, and signed off (link 1.3.8.2). Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at two monthly meetings. If there is an emergent issue, it is acted upon in a timely manner.</p> <p>The service has continued to reduce the incidence of urinary tract infections. Overall infection rates are low and there has been no outbreak since previous audit.</p> <p>The infection control committee reviewed the incidence of urinary tract infections. The service identified best practice using latest clinical resources. The service was awarded a rating of continuous improvement at the last audit, and the work has continued to show a reduction in the number of urinary tract infections.</p> <p>Covid 19 prevention strategies and risk management plans are part of the overall infection control prevention programme. Residents and staff are vaccinated. Relatives and Visitors are required to contract trace, sign Covid 19 symptom declarations and wear masks.</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 around restraint minimisation. A registered nurse is the restraint coordinator. There is a restraint and enabler register available (sighted). There were no residents using a restraint. There were four residents with enablers (three lap belts and one bedrail). The residents with an enabler had a documented assessment and consent. The care plan included the enabler and risk associated with its use. Monitoring had been completed as per the care plan.</p> <p>Staff receive training on restraint minimisation and challenging behaviour in June 2021. The caregivers and RNs interviewed were able to describe the difference between an enabler and a restraint.</p>
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## 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 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Care plans and interRAI assessments had been completed for all residents' files reviewed. Three (two hospital and one rest home level of care) of five reviewed did not always document detailed interventions needed to support the resident needs. The shortfall identified at the previous audit around interventions has not been addressed. The risk rating has been raised in this audit to moderate and the length of time to address the issue raised from 90 days at the last audit to 60 days.</p>	<p>The following shortfalls were identified:</p> <p>i) One rest home resident had a care plan completed and then the interRAI was completed two months later. The care plan has not been updated to include the cardiopulmonary triggers identified in the interRAI to include management of shortness of breath and diuretic use.</p> <p>ii) The resident (YPD) presents with advanced Parkinson's and receives continuous</p>	<p>i) Ensure interRAI triggers are addressed in the care plan and care plans are evaluated in line with the interRAI.</p> <p>ii -iii) Ensure that interventions</p>

			<p>subcutaneous infusion for diaphragmatic pain and shortness of breath. The change in pain management and infusion management, including subcutaneous site care, had not been addressed.</p> <p>iii) One resident on palliative care was rapidly deteriorated. The interventions in the care plan did not support his needs for end-of-life comfort care including spiritual and cultural needs.</p>	<p>are recorded to a level of detail to support the needs of the resident.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	<p>Short term care plans and goals and interventions documented. Ten short term care plans were reviewed: two for wounds and eight related to infections. Short term care plans related to wound management were signed off as resolved. Six short term care plans related to infections were not signed off as resolved and two have not been evaluated since inception or signed off.</p>	<p>Eight of ten short term care plans within the sample of files reviewed developed for infections were not always evaluated or signed off.</p>	<p>Ensure short term care plans are evaluated and signed off as resolved.</p> <p>90 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.