

Heritage Lifecare Limited - Pururi Court Rest Home and Hospital

Introduction

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

The audit has been conducted by Health Audit (NZ) Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Pururi Court Rest Home and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 October 2015 End date: 15 October 2015
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:	71

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.

General overview of the audit

Puriri Court Rest Home and Hospital is a privately owned 72 bed facility for residents requiring rest home and hospital level care. This provisional audit was undertaken to establish the prospective owner's preparedness to provide a health and disability service and the level of conformity with the required standards of the existing provider's services and to assess the current status of services offered.

The audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included review of policies and procedures, the review of staff records, observations, and interviews with residents, family/whanau, management, staff, the current provider and the prospective providers quality and compliance manager.

The existing services had no areas requiring improvement identified in the audit.

The prospective provider has aged care management experience and has no immediate plans to change any systems or services.

Consumer rights

Staff interviewed demonstrated good knowledge and understanding of respecting residents` rights in their day to day interactions. Staff receive education on the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` Right (the Code). Advocacy services are available and contact numbers accessible. Interpreter and translation services are accessible, if required.

There were two residents who identify as Maori at the service at the time of the audit. There are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written informed consents are obtained from the resident, representative, family/whanau, enduring power of attorney, as needed. Signed informed consent forms were sighted in the residents` records reviewed.

Open disclosure and effective communication is encouraged by staff and the contracted general practitioner for all incidents and accidents and any untoward events.

Linkages with family and the community are encouraged and promoted.

Complaints are well managed and seen as an opportunity to improve services.

Organisational management

Puriri Court has an established quality and risk management system that supports the provision of clinical care and support. Policies and procedures are current and reflect best practice, legislation and standards. Quality related data is collated and used to continually improve services. Risks to service are identified and managed.

The orientation/induction programme provides new staff with relevant information for safe work practice. The in-service training programme covers relevant aspects of care and support that meets requirements.

There is a system for determining staffing and skill mix for safe service delivery over the 24 hour period. Residents and relatives confirmed that they have adequate access to staff.

The prospective provider is an established organisation with experience in the aged care setting. The quality and risk management plan and business plan ensure the safe and efficient transfer of ownership and management.

Continuum of service delivery

Pre-admission information clearly and accurately identifies the services offered. The service agreements are signed by the resident, family and/or enduring power of attorney on admission to the service.

Services are provided by suitably qualified and skilled staff to meet the needs of residents. All admissions have a comprehensive interRAI assessment completed by a registered nurse. Timeframes for the development of the long term care plans are met. Short term care plans are implemented if there is a change in the resident's needs.

The registered nurses are responsible for evaluating the long term care plans using the interRAI assessment process.

The general practitioners review their residents on admission to the service and then monthly for the hospital level residents and three monthly for the rest home residents. Reviews occur more frequently if required and the care plans are updated respectively. Referrals to other health and disability services are planned and co-ordinated, based on the individual needs of the resident.

A safe medication system was observed at the time of the audit. The staff responsible for medication management have completed annual competencies and ongoing training.

There is a planned activities programme to meet the social and recreational needs of the residents. Residents are encouraged to maintain links with family/whanau and the community.

The residents' nutritional requirements are effectively met by the service with preferences and special diets catered for appropriately with registered dietitian input. The service employs experienced staff who prepare the meals from a six week rotating menu plan that is also approved by the dietitian.

Safe and appropriate environment

The building has a current building warrant of fitness. The physical environment is designed to be homely and to minimise the risk of harm. Maintenance requirements are monitored. The hospital and rest home wings have space to ensure the needs of residents are met. Electrical and medical equipment is maintained and in safe working order.

There are documented cleaning and laundry procedures. Personal protective equipment is readily available. Appropriate training, information, and equipment for responding to emergencies are provided. There is an approved evacuation plan and fire drills are conducted as required. The facility has civil defence kits and emergency management plans in place.

The prospective provider has no immediate intention of making any changes to the building or plant.

Restraint minimisation and safe practice

Policies and procedures in place reflect current good practice and meet legislative and Health and Disability Services Standards requirements. The service operates a restraint minimisation and safe environment. Staff interviewed have a full understanding of what is required when restraint/enablers are used. Education is provided to all staff. A restraint register is maintained. The restraint minimisation and safe practice is linked to the quality and risk management system.

Infection prevention and control

The infection and control management system is appropriate for the nature of this service. The annually reviewed programme is implemented and reduces the risk of infections to residents, staff, family/whanau and visitors. The policies and procedures reflect current accepted good practice. Relevant education is provided for staff and when appropriate the residents. Hand hygiene is promoted. The registered nurse infection control coordinator completes a monthly surveillance programme, where infection data is collated, analysed and trended with previous data. Where any trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the monthly staff meetings. Advice is readily available from expert advisors as needed.

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	50	0	0	0	0	0
Criteria	0	100	0	0	0	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The consumer rights policy contains a list of rights congruent with the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` Rights (the Code). The Code is displayed and available to all residents and is monitored to ensure the rights of residents are respected. New residents and family are given a copy of the Code in the information pack on admission.</p> <p>Staff receive education on the Code at commencement of employment as part of the orientation process. The Code is available in English, Maori and other languages for residents with English as a second language.</p> <p>The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practices.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed</p>	FA	<p>A detailed informed consent policy is documented and implemented. Systems and processes are in place to ensure residents and where applicable their family/whanau are provided with accurate and</p>

<p>choices and give informed consent.</p>		<p>appropriate information to assist them to make an informed decision and to give informed consent. The staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Residents interviewed confirmed they have been made aware of and understand the informed consent process and that appropriate information is always provided. There is a brochure stand in the reception area accessible to residents and families.</p> <p>Currently a multi-purpose informed consent form is utilised by the service provider and a copy is retained in the individual resident records sighted. Forms reviewed were signed and dated appropriately. The individual resident admission agreements when signed and dated are stored confidentially in the manager`s office.</p> <p>The operations manager, registered nurses and clinical nurse manager interviewed understand their obligations and the legislative requirements to ensure competency of residents as required for advance directives. Reviews of residents are undertaken six monthly. Reviews of health status are documented on the appropriate form available and retained in the individual resident`s records. Family are invited to participate in the six monthly reviews by letter. The letter sighted is sent to families from the clinical nurse manager and the activities coordinator. Family are available to provide any feedback if required.</p> <p>Registered nurses interviewed reported they received orientation/induction in the principles and practice of informed consent as part of the Code of Rights and evidence an understanding of the Code.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>The advocacy policy documented ensures that all residents receiving care both short or long term within this organisation have appropriate access to independent advice and support. This includes access to a cultural and spiritual advocate when required. The service has both a Maori health advisor and a Kaumatua.</p> <p>Family and residents interviewed reported they were provided with appropriate information regarding access to advocacy services on entry to the service. Contact numbers are documented on the reverse of the Health and Disability Service Consumers` Rights brochure sighted.</p>

		Relevant education for all staff is conducted as part of the in-service education programme as confirmed by staff interviewed.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Family and friends of residents are encouraged to visit. This is confirmed by family and staff interviewed. Family are welcome to participate in the activities programme and special events are organised for family to attend several times a year. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. The service has a bus and a van. Bus outings in the local community and surrounding areas are arranged twice a week by the two activities coordinators. This was verified in the activities programme reviewed and reported by residents and staff interviewed.</p>
<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>Staff, residents and families interviewed were aware that residents, and where applicable, their representatives have the right to make a complaint. Information regarding the complaints process and advocacy services is readily available. There is an established complaint management system. All complaints are listed on the complaints register and are compiled with appropriate timeframes to meet Right 10 of the Code. There was one complaint investigated by the Health and Disability Commissioner in 2015. This complaint has been resolved and no further action was required. There are no other complaints reported to the coroner, ACC or other external agencies.</p> <p>In addition, any concerns voiced at resident meetings are followed by management and reported at the next meeting. Resident newsletters also keep residents informed of any action taken to improve services.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The clinical nurse manager interviewed identified that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family/whānau on admission and that the admitting registered nurse is to go through the Code with the resident/family on admission as part of the admission</p>

		<p>process.</p> <p>The residents and family members that were available for interview reported that the Code was explained to them on admission and this was included in the admission pack provided. Residents interviewed who were able to provide insight into their care expressed that they were treated with respect and were happy at the facility.</p> <p>An interpreter and translation service is available and accessible. The District Health Board (DHB) provides Maori health advisers and an advocacy service which could be accessed on a referral basis. The prospective provider representative interviewed has an understanding of consumer rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>A dignity and privacy policy is implemented. The wishes of residents are acknowledged, sexuality and personal rights are upheld, independence maintained, maximised and encouraged.</p> <p>The family/whanau members interviewed reported that their relatives are treated in a manner that shows regards to the resident's dignity, privacy and independence.</p> <p>The residents' records reviewed indicated that residents received services that were responsive to their needs, values and beliefs of culture, religion and ethnicity.</p> <p>The families interviewed reported satisfaction with the way that the service meets the needs of their relatives. Church visitors are welcome to visit residents and a service is held monthly. Communion is offered on a regular basis.</p> <p>As observed and confirmed during the audit the individual resident's records randomly selected for review had interventions in place to meet all residents' identified needs. No concerns in relation to abuse and neglect have been reported and policy is in place should any incidents occur or be suspected. Comments made from staff, family and residents reflected a positive atmosphere.</p>

<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has a Maori health plan which acknowledges the organisation`s responsibilities to Maori residents in accordance with the Treaty of Waitangi. The organisation is committed to identifying the needs of its residents and ensuring that staff are trained and capable of working appropriately with all residents in their care. The provision of culturally appropriate services and the identification and reduction of barriers are part of the organisation`s documented Maori health plan objectives reviewed.</p> <p>Rooms are blessed as required. The service has an accessible cultural advisor and a Kaumatua who provide services as required.</p> <p>There are currently two residents and nine staff who identify as Maori. When residents are admitted to the service a cultural needs assessment is completed by the registered nurse prior to the long term care being developed to ensure all cultural, values and beliefs are identified and managed effectively. The healthcare assistants interviewed demonstrated good understanding of services that would need to be provided for Maori residents to meet identified needs and the importance of whanau.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The spiritual, religious and cultural policies and procedures provide information to guide staff on protocol. A cultural needs assessment tool is available to ensure the identified needs can be effectively met. These assessments were sighted in the residents` files reviewed. The resident`s individual iwi is also documented on the resident information record. Staff reported they received training in cultural awareness. Cultural needs were documented on the resident individual long term care plans sighted.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff records reviewed have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. The discrimination policy reviewed has clear definitions of discrimination. The clinical nurse manager and the registered nurses have completed mandatory professional boundaries workshops which is</p>

		a requirement for the New Zealand Nursing Council.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The clinical nurse manager interviewed promoted and encouraged best practice with staff. Evidence of this was demonstrated in interviews with registered nurses and health care assistants. Policies and procedures are developed by a contracted quality consultant and implemented and monitored by the management team on a regular basis. Procedures are linked to evidence-based practice. The GPs are available to have a discussion with family/whanau if and when required and to visit residents as needed.</p> <p>The family and residents interviewed expressed satisfaction with the overall care and activities delivered.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>The open disclosure policy is developed and implemented. The policy is based on the principle that residents and their families have a right to good explanations and to know what has happened to them at all times. The family communication record in each of the individual randomly selected resident records reviewed, evidenced this does occur.</p> <p>Family and residents interviewed confirmed that they are kept informed of any events adversely affecting the resident or any changes in medication, treatments, procedures that affect the resident.</p> <p>Evidence of open disclosure was documented in the progress notes and through the incident/accident system as explained by the clinical nurse manager and the registered nurses at interview. Records randomly selected could be followed through effectively.</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>	FA	<p>Puriri Court is certified to provide rest home and hospital level care to up to 72 residents. On the days of audit there were 71 residents – 28 rest home residents and 42 hospital residents. The provider has 10 beds which can be used for either rest home or hospital residents. The provider also has additional contracts from the district health board to provide medical services.</p>

		<p>Governance of the business is provided by the owner/ director. The director ensures that services are provided in accordance with expectations as documented in the business, quality risk and management plan. The plan documents the mission, philosophy and objectives. The director reviews the plan every year in consultation with the operations manager. On-going organisation performance is monitored by the director through financial and management reports.</p> <p>The operations manager has 30 years of aged care experience and has been in the role since February 2012. The operations manager for the current provider is the facility manager. In interview, the director confirmed confidence in the performance of the operations manager. The operations manager is an active participant/leader in the community and aged care sector and maintains the required training hours.</p> <p>The prospective provider is an established organisation with clear lines of reporting to the governing body. The prospective provider has a background in the ownership and management of aged care facilities. The acquisition plan includes timelines for implementation and responsibilities. Acquisition activities are monitored at senior management team meetings. This includes progress towards key targets. In interview, the prospective provider's representative reported that all acquired facilities receive on-going support from the clinical operations manager and quality and compliance manager.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>The operations manager is supported by the other members of the management team. This includes the clinical manager and accounts manager, both of whom perform the role of the operations manager during a temporary absence.</p> <p>The prospective provider also has an established senior management team. The management team includes the general manager, policy and compliance manager, clinical operations manager and a finance manager. In interview, the prospective provider's representative reported that there were no plans to make changes to the current management team at Puriri Court.</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>	<p>FA</p>	<p>The service has a range of policies and procedures to support service delivery, risk management and quality outcomes. Policies and procedures are maintained as controlled documents and are reviewed bi-annually or sooner if required. Policies include reference to standards, legislations and best practice, including the interRAI Long-Term Care Facilities Assessment System (InterRAI LTCF). Staff confirmed access to the required policies and procedures. Obsolete documents are removed from circulation and a copy maintained. It is reported that the prospective provider's policies and procedures will be introduced over time. The prospective provider's representative reported that their policies and procedures meet the requirements of the Health and Disability Services Standards</p> <p>The business, quality risk management plan details all quality activities and is reviewed annually to measure achievement. Key components of service delivery are linked to the quality and risk management system including resident satisfaction surveys, health and safety, the management of adverse events, restraint minimisation, and infection prevention and control. Data is evaluated and results used for quality improvement. There are a number of quality meetings held including a monthly continuous quality improvement (CQI) meeting, monthly staff meetings, monthly management meetings, monthly registered nurse (RN) meetings and two monthly resident meetings. Information on quality and risk management is conveyed to staff through handover sessions, monthly staff meetings and displayed in the staff room.</p> <p>Internal audits cover the scope of the quality system. Audits are conducted by the designated compliance officer against the audit schedule. Corrective actions are implemented when required.</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The service maintains a risk register and a hazard register. Risks are identified, monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk. The required insurances and financial management systems are in place including business interruption and liability insurance.</p>
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		<p>Work place health and safety requirements are met. The provider as achieved tertiary level Accident Compensation Corporation (ACC) workplace safety management practices.</p> <p>The prospective provider has a predetermined lead-in time. There is an annual business plan and quality and risk management plan. The prospective provider's representative reported that the current quality and risk management system will remain in the meantime, with overview provided by the quality and compliance manager. This includes the current system of internal audits.</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>The incidents and accidents policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and the need to identify corrective actions to minimise reoccurrence. Staff document adverse events at the time of the event. All events are investigated using a structured method that requires immediate attention, effective escalation and address the root cause.</p> <p>Events sampled confirm that residents received appropriate clinical care from a registered nurse in a timely manner and the required notifications are made. Events are reviewed and collated monthly. Trends are monitored. The results of incidents and accidents are discussed at CQI and staff meetings. Management are aware of the need to notify relevant authorities in relation to essential notifications.</p> <p>The provider is also participant in a falls prevention programme and comparisons are made to ensure the falls rate for residents' remains at an acceptable level. Records sampled confirmed that the Puriri Court falls rate is lower the average within the local DHB area.</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>Human resource policies and procedures meet the requirements of legislation. Prospective employees undergo reference checking and police checks. Aptitude tests are also conducted on prospective employees to ensure best fit within the culture of the organisation. Qualification is validated for both employed staff and allied health providers.</p>

		<p>New employees complete an orientation programme which includes the essential components of service delivery. An orientation book is provided. All new staff work with an identified 'buddy' for a minimum of two shifts.</p> <p>An annual in-service education programme is in place and a record of education attendance and achievement is maintained. Ongoing training meets the requirements of contracts and the operations manager has a system to follow up on all employees who are unable to attend. All health care assistants are encouraged and supported to complete the relevant aged care qualifications. Registered nurses are supported to meet their professional development obligations including interRAI training. The service meets its interRAI obligations with regard to trained registered nurses. Annual appraisals are conducted for all employees. Records of the required competencies, including medication competencies, are maintained.</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 mix for safe service delivery. Rosters are developed by the clinical manager using safe staffing acuity tools provided for the aged care sector and recognised by the New Zealand Nurses Organisation (NZNO). The roster provides sufficient and appropriate coverage for effective delivery of care and support. The operations manager and clinical nurse manager work 40 hours per week and are supported by the compliance quality officer who is a RN and who works three days in the role on average. The clinical nurse manager and the compliance quality officer share on call duties for clinical matters. It is reported that staff turnover has been stable and that agency staff are not required.</p> <p>The prospective provider's representative confirmed that the current staffing will be maintained and that staffing numbers are based on the industry standards for aged care. Reports on staffing are provided to the senior management team in monthly management reports.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded,</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. This includes comprehensive information</p>

<p>current, confidential, and accessible when required.</p>		<p>gathered, at admission. There is sufficient detail in residents' files to identify residents' on-going care history and activities. There are policies and procedures in place for privacy and confidentiality. Files and relevant resident care and support information can be accessed in a timely manner. Entries in resident records are legible, dated and signed by the relevant staff member including designation. Resident's files are protected from unauthorized access and unique identifiers are used.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The operations manager is responsible for managing the enquires about the service. Information is recorded as part of the pre-admission information. There is an information pack available for this care setting. There is adequate information about the service provided as well as a brochure. The contact details of the clinical nurse manager are included in the pack in case families wish to discuss any further issues or obtain any further information from the clinical nurse manager.</p> <p>The resident agreement is based on the Aged Care Association Agreement which is individualised to the service. The resident agreements sighted were signed and dated by the resident/representative and the operations manager. The admission agreement identifies any additional charges that are not covered by the service agreement and the relevant costs of each charge required. Incontinence products are only charged if the resident or family chooses a brand that is different to those provided by the facility.</p> <p>All residents at the facility have been pre-assessed by the district health board needs assessment co-ordination service (NASC) or hospital health services for older persons geriatrician as requiring either rest home or hospital level care. The NASC interRAI assessments are retained in the individual resident's records but the approval/authorisation (NASC) confirmation letters are with the service agreements in the manager's office.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit,</p>	<p>FA</p>	<p>The clinical nurse manager interviewed stated risks are identified prior to planned discharges or transfers. Should a transfer need to be arranged to the DHB the 'yellow bag system' a DHB requirement is</p>

<p>discharge, or transfer from services.</p>		<p>utilised. Staff ensures open disclosure between services, family/whanau relating to all aspects of service delivery. This includes residents for either discharge and/or transfer to another facility or the DHB.</p> <p>If there are any specific requests or concerns that the resident or family want discussed, these are noted on the designated transfer form. The discharge form and care plan summary is provided and covers all personal cares and interventions. If there are any known alerts, risks or concerns these are highlighted. If a transfer occurs to the DHB a copy of the medication chart with any known allergies and/or sensitivities, the resident information page and/or any advanced directives also accompany the resident if they are transferring to hospital.</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>Policies and procedures are available to guide staff. The sighted policies meet the legislative requirements and best practice guidelines. The medications are managed by the registered nurses on each shift due to the nature of the service providing both rest home and hospital level care. All have completed annual competencies. Two trained senior healthcare assistants assist with the medications alongside the registered nurse. This a new initiative introduced by the clinical nurse manager and the senior healthcare assistants are fully trained to perform this role. All staff administering the medications wear aprons to distinguish they are not to be disturbed during this procedure.</p> <p>The pre-packed delivery system for medicines is utilised and the registered nurses check all medications on arrival from the contracted pharmacy. The medications are stored in lockable medication trollies which are stored in the two medication rooms available. Controlled drugs are minimised but stocks are checked weekly every Saturday by two senior staff and the register is maintained.</p> <p>A safe medicine management system was observed on the day of the audit. The clinical nurse manager stated there have been no recent medication errors with the two person system in place. There is clear evidence of medication reconciliation and the pharmacy completes pharmacy audits six monthly.</p> <p>The medication records reviewed are reviewed by the GP monthly for hospital level residents and three monthly for the rest home level</p>

		<p>residents or more often if needed. Reviews are documented on the medication records sighted. All medications charted are dated and signed off by the GP. There is a staff specimen signature list for all staff who administer medications. The individual resident medication records have photographic identification. The medication signing records are completed by the pharmacist and each medication administered is signed off by one of the registered nurses.</p> <p>The medication fridge and the medication rooms are monitored daily. Records were reviewed and all are well maintained. There are no residents self-administering except for the use of inhalers. The GP concerned has reviewed these residents and approved the use of the inhalers. A self-administration policy is developed and implemented. Additional medications and treatments are documented and a schedule of requirements is available to guide staff for example Vitamin B12 injections, supplement drinks. A list of residents requiring eye drops to be instilled on a regular basis was sighted. Staff have stamps with their name and registration number and these can be clearly identified on the medication records reviewed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There are two main cooks and a relief cook. The relief cook interviewed was well informed about food handling and safe practices to meet all requirements. The food safety management education undertaken by all kitchen staff is appropriate to service delivery.</p> <p>Policies, procedures and guidelines are available that are current and up-to-date and include a separate cleaning schedule, temperature monitoring requirements, hygiene standards for staff, purchasing of food, checking deliveries, storage and waste management.</p> <p>Regular monitoring and surveillance of the food preparation and hygiene is performed and records were sighted. There is evidence of fridge/freezer temperature recordings which meet food safety requirements. The six week menu plans had been reviewed by a New Zealand registered dietitian and verification was provided. The menu rotates and summer and winter menus are prepared. The dietitian is available on a referral basis. The main kitchen is well designed and functional. The dining room is in close proximity for serving meals.</p>

		<p>There is a second kitchen which is used for residents who are more independent. An adjacent smaller dining room is set up each meal time. Residents can make beverages through the day for family and friends. Kitchen staff monitor the fridge in this area as well.</p> <p>A nutritional profile is completed for each resident as part of the interRAI assessment process on admission and this information is shared with the kitchen staff to ensure all needs, wants and preferences and special diets are catered for.</p> <p>The families and residents interviewed reported satisfaction with the meal service.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complies with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The clinical nurse manager interviewed reported that the service does not refuse a resident admission if they have the suitable needs assessment to ascertain the level of care required and that there is a bed available.</p> <p>In the event that the service cannot safely meet the needs of the resident, the resident and family will be contacted so that alternative residential accommodation can be arranged. An interRAI assessment is required to be completed by a registered nurse if a resident moves to an alternative service provider. This could occur in the event of a resident requiring a secure dementia service for ongoing dementia care. The service provides respite, rest home and hospital level care to residents.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All new residents admitted to this facility have an interRAI assessment completed and/or are in progress. The first interRAI is completed within twenty four days of admission. The assessments include the review of any previous interRAI assessments such as homecare and/or needs assessment service coordinators comments. Any additional assessments are completed such as continence, pain, cultural, skin pressure areas prevention, falls risk assessments, nutritional, and other assessments as required specific for the individual resident.</p>

		<p>The residents` records reviewed evidenced the electronic assessments are currently printed and included in the hard copy residents` records. Results of the assessments are discussed with the resident and family/whanau and included in the care plan as needed.</p> <p>Residents, staff and families interviewed reported appropriate care is provided that meets identified needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The residents` records have care plans that address resident`s current abilities, level of independence, identified needs/deficits, and takes into account the resident`s habits, routines and idiosyncrasies. The strategies for minimising falls risk on assessment and use of techniques that are effective were evidenced in the records reviewed. The interRAI assessment has an assessment summary which includes triggered outcome scores and the needs, identified by the registered nurse completing the individual resident assessment. These findings are documented onto the care plan.</p> <p>The clinical nurse manager and registered nurses interviewed demonstrated understanding of the interRAI process.</p> <p>The care plans and activities plans identify resident`s individual activities, motivational and recreational requirements with documented evidence of how these are managed effectively for the individual resident. Appropriate interventions were documented on each care plan sighted for each identified need. The care plans were comprehensively documented.</p> <p>The individual care plans sampled included five hospital level and four rest home level residents. The records demonstrated integration with dividers between each section.</p> <p>The clinical nurse manager, registered nurses, general practitioner and healthcare assistants reported they receive adequate information to assist with the continuity of care for each individual resident.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	FA	<p>As observed on the days of the audit and from review of the long term care plans, support and care was individualised and focused on</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>achieving desired outcomes/goals set. The clinical nurse manager, registered nurses and healthcare assistants interviewed demonstrated good skills and good knowledge of the individual needs of residents. The residents' records showed evidence of consultation and involvement of the family. The residents interviewed reported satisfaction with the care and services provided.</p> <p>Short term care plans are developed as necessary for any event that is not part of the long term care plan, such as monitoring weight loss; vital signs and wound/skin tear management.</p> <p>There are adequate supplies of wound and continence products to meet the needs of the residents. The long and short term care plans recorded interventions that are consistent with the residents identified needs being able to be met. Observations on the days of audit indicated residents are receiving appropriate care that is consistent with their needs. The clinical nurse manager and registered nurses interviewed reported the care plan interventions are accurate and up to date.</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>	<p>FA</p>	<p>The activities programme ensures residents' individual motivational, recreational, social and cultural needs are recognised. Each resident is assessed on admission to the service. The residents have the opportunity to maintain interests, choices and activities in a continuing care environment. The activities programme sighted is based on the residents' needs, interests, skills and strengths and covers cognitive, physical and social needs.</p> <p>The activities programme implemented is planned monthly. A copy of the programme is displayed in all areas of the home on notice boards provided. Resident meetings are held two monthly and minutes of the meetings are available and a copy displayed on the noticeboard.</p> <p>There are two activities coordinators each with different skills. One activities coordinator covers five days a week and the other four days a week. The programme sighted offers a variety of activities. Activities are planned that are meaningful to the residents. An attendance record is maintained of each resident's participation. However, it is voluntary to attend and this is respected by the activities coordinators and staff. One on one activity arranged for hospital level residents who are unable to</p>

		<p>attend a group session. Each resident's activities plans are reviewed six monthly to ensure goals are evaluated and updated as required. The activities plans and care plans are reviewed at the same time and the resident/family are invited to be involved with the review.</p> <p>Residents are encouraged to maintain links with family/whanau and the community. The service has a bus and a van for outings in the community. Special days are celebrated, for example birthdays, anniversaries, cultural days and other special events.</p> <p>Church services are held monthly and Christian groups visit regularly. Communion is available to meet needs of individual residents.</p> <p>Residents were visibly enjoying the activities seen during the audit and residents interviewed reported that they enjoy the range and variety of planned activities arranged by the two coordinators and support and involvement of the staff.</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>Long term care plans and activities plans are reviewed six monthly or more often if required. Evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting these goals. If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with their GP. The care plans sighted are comprehensive and clearly describe the interventions needed to achieve set goals. Short term care plans are instigated if and when required. Short term care plans are developed for wound care, infections, mobility changes, significant weight loss or other reasons. These processes are clearly documented on the short term care plan, medical and nursing records and the individual resident's progress records.</p> <p>The registered nurses interviewed demonstrated good knowledge of short term care plans and information is shared at handover with the clinical nurse manager on a daily basis each week day late morning and with the healthcare assistants at handover between shifts if relevant.</p> <p>Families reported that they can consult with staff at any time if they have any concerns or when there are changes in the resident's condition.</p>

		This is documented on the family communication record in all resident records reviewed.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are provided with options if required to access other health and disability services. The GP or the clinical nurse manager can arrange a referral to NASC should a needs assessment be required. InterRAI assessments will be used to facilitate the assessment process without a physical review occurring when the process is well implemented and embedded into the service.</p> <p>The GP is responsible and arranges for any medical specialist or surgical service referrals through the out-patient clinics at the DHB. The registered nurses at interview stated that referral response times are managed promptly. Should an acute resident transfer need to be arranged this will be arranged by the GP and/or the staff on duty at the home. The registered nurses interviewed understood the process for external transfer and the yellow bag system implemented.</p> <p>Resident records reviewed confirmed that copies of referrals are retained in the individual resident's record.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Staff are guided by a policy on the management of waste and hazardous substances. There is a policy on the use of chemicals to ensure effective management of potentially hazardous substances (e.g., for spill management and blood and body fluids). There is a process for disposing of infectious and hazardous waste (e.g., sharps). Staff have access to personal protective equipment. The hazardous substances register is current. Material data safety sheets are easily accessible. Oxygen cylinders are secure and there is sufficient safe storage for chemicals. Contenance products are disposed of appropriately. There have been no reported incidents regarding waste of hazardous substances.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>The facility has a current building warrant of fitness. The physical environment is appropriate to the needs of the residents. Planned and</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>reactive maintenance systems are in place. Medical equipment is calibrated and tested. Hot water temperatures are checked monthly. Electrical tagging is done annually onsite by maintenance manager, who is qualified to use the testing tool. Equipment is safely stored. Monthly environmental audits are conducted to ensure all requirements are maintained.</p> <p>Corridors are wide enough to allow residents to pass each other safely. Safety rails are secure and appropriately located. There are minimal changes in floor surfaces. Equipment does not clutter passageways. The external areas are safely maintained and are appropriate to the resident group. They include seating and shade. There are two internal courtyards.</p> <p>Registered nurses and health care assistants confirmed that they have access to appropriate equipment. Residents and staff interviewed confirm they know the processes they should follow if any repairs/maintenance are required and that requests are appropriately actioned. Residents interviewed confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>In interview, the prospective provider's representative reported that there are no planned changes to the facility or plant.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>Residents have access to an adequate number of toilets and showers. The hospital wing contains some rooms with ensembles. There are communal toilets and showers throughout the premises. There are adequate communal toilets that are easily accessible and signed. There are separate toilets for visitors and for staff.</p> <p>Staff and residents have access to adequate hand washing facilities throughout the facility. Fixtures and fittings in toilets, and showers are able to be cleaned easily and comply with infection control guidelines.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas</p>	<p>FA</p>	<p>There is adequate room in each resident's bedrooms for personal belongings and there is sufficient room for both staff and residents to move around easily. Residents' rooms all have single doors in two wings</p>

<p>appropriate to the consumer group and setting.</p>		<p>and double doors in the other wings. There are two shared rooms which are currently occupied by married couples.</p> <p>The only time residents are required to be transferred from their bedrooms is in an emergency situation and the registered nurses confirm that ambulance gurneys have no problem with access.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are three lounge areas (one in each wing) to allow for activities, resident relaxation and privacy when having visitors. Communal areas are bright and airy and allow freedom of movement for all residents including those with mobility aids. There are three dining areas (one dining area in each wing). There is room for outdoor relaxation and there are two internal courtyards.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>The service has in place policies and procedures for effective management of cleaning and laundry practices. These include the management of clean and dirty linen within the laundry. Chemicals dispensers are able to be locked when not in use. Staff are trained in the use of chemicals. All laundry is done in house. There are two laundries on site and two staff typically to do the laundry. Chemicals are stored in fixed containers in the laundry. Each laundry has commercial washers and driers. There are also two sluice rooms and a separate folding and ironing room in the hospital wing for clean laundry. There is a laundry manual available that includes the use of personal protective equipment, handling of linen, waste disposal and with hazard controls. Laundry and cleaning processes are monitored for effectiveness by internal audits, chemical supplier feedback and resident meetings.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Documented systems are in place for essential, emergency and security services. There are procedures for the safe and appropriate management of unwanted and/or restricted visitors. There are emergency management plans to ensure health, civil defence and other emergencies are included. There are two emergency trollies. There is an approval of fire evacuation scheme and staged evacuation trials are</p>

		<p>conducted as required.</p> <p>All registered nurses and the majority of health care assistants have a current first aid certificate. Emergency and security situation education is provided during orientation. This includes fire safety training and emergency security situations. Staff records sampled confirmed current training regarding fire, emergency and security education.</p> <p>Information in relation to emergency and security situations is readily available/displayed. Emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. The facility has sufficient emergency supplies in the event of a civil defence emergency.</p> <p>There is a call bell system that is easily used by the resident or staff to summon assistance if required. Call bells are accessible / within easy reach, and are available in resident areas. Cameras are also situated within the central corridors.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Each common area and bedroom has access to an external window and are well lit with natural light. The building is ventilated by opening doors and windows. Heating is by central heating. The maintenance manager monitors temperatures using wall barometers. Residents are not exposed to secondary smoke.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service has a documented infection control programme which is reviewed as part of the annual review. The infection control programme aims to minimise the risk of infections to residents, staff, family/whanau and visitors to the facility. The policies and procedures are current and up-to-date and accessible for all staff.</p> <p>The infection control coordinator (ICC) is a registered nurse. A job description is available which states clear guidelines for the accountability and responsibilities involved with this role. The ICC monitors all infections, uses standardised definitions to identify infections appropriately, surveillance and monitoring of organisms, related to antibiotic use. Monthly records are maintained. Infection</p>

		<p>control is presented at each staff meeting.</p> <p>The ICC interviewed reported staff fully support the programme and have good assessment skills in the early identification of suspected infections. This was also addressed with the healthcare assistant interviews staff reported how they notify the registered nurses if they have any concerns when caring for residents. The shift handover observed is a forum for reporting incidences of infection. Short term care plans are used, for example for wound care and other infections and fluid balance records are also discussed and used when required.</p> <p>A process is identified in policy for the prevention of exposing others to infection. Health care assistants and registered nurses at interview stated they knew when not to come to work and when to return from sick leave. Signage was sighted in use in the facility. Sanitising gel is readily available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Infection control advice can be sought from the GPs that visit the facility, microbiologist or from the infection control nurse specialists and the DHB if and when required. The clinical nurse manager stated that the GP and the infection control team are fully informed of the responsibilities and reporting obligations if needed for notifiable infection outbreaks or diseases. There have been no infection outbreaks since the last audit.</p> <p>The ICC interviewed demonstrated good prevention and control techniques and awareness of standard precautions.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection control committee meets regularly to discuss and report any issues to the monthly staff meetings. The committee consists of the ICC, two registered nurses, the clinical nurse manager and two senior healthcare assistants (team leaders), a cleaner and laundry representatives. The service has access to the DHB infection control team nurse specialist, the laboratory microbiologist and GPs that visit the facility.</p> <p>The clinical nurse manager, registered nurses and healthcare assistants interviewed demonstrated good knowledge of infection prevention and control.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The policies and procedures reviewed January 2015 set out the expectations the service uses to minimise infections. This is supported by the infection control policies for specific infection control areas such as antibiotic use, methicillin resistant staphylococcus aureus (MRSA) and other antimicrobial screening, wound care management, blood and body spills, cleaning and disinfectant are covered. Standard precautions are adhered to throughout all of service provision and signage is available.</p> <p>Observations at the onsite audit identified the implementation of infection prevention and control procedures. Staff demonstrated safe and appropriate infection prevention and control practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Infection control education is provided by all registered nurses. Infection control education is included in the orientation/induction to service and as part of the ongoing in-service education programme. The ICC stated that opportunity arises at each staff meeting and this is used as a forum to report and discuss and educate staff on any infection control issues or trends identified. A record of topics and attendees is maintained by the ICC. Evidence of education provided by the DHB was displayed on the notice board in the staff room. The staff education records were accessible and reviewed.</p> <p>Resident education is conducted as required. Hand hygiene was promoted at every opportunity for staff, residents and visitors to the facility.</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>The infection control surveillance programme is appropriate to the size and nature of the services provided. All staff are involved and take responsibility for surveillance activities as shown in the policy reviewed and staff interviewed. An infection report form is completed as soon as signs and symptoms have been identified and given to the registered nurses or the ICC directly. Monitoring is described in the infection control programme to ensure residents` safety at all times.</p>

		<p>The ICC interviewed explained how the infections are collated for the monthly surveillance report. The monthly analysis of the infections includes comparison with the previous month, reasons for an increase, achievements or decreased infections and actions taken to reduce infections. The analysis includes a feedback summary that is provided to staff.</p> <p>The surveillance programme results are discussed at the staff meetings held monthly.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are twelve residents using restraints and two residents using enablers. Restraint use has been actively minimised over the last 18 months with new strategies and restraint minimisation management. Policies and procedures are in place to guide staff to use restraint safely if required. Enablers are used voluntarily and the least restrictive option to meet the needs of an individual resident. Enablers are clearly described in accordance with Health and Disability Sector Stands requirements.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Processes implemented as per policy reflect safe use of restraint and enablers. The restraint coordinator / registered nurse interviewed has a good understanding of restraint minimisation and safe practice. The approval group comprises of the restraint coordinator, the general practitioner and the clinical nurse manager. Policy identifies the role of the approval group. Approved restraints /enablers are documented in the restraint register. Restraint use is documented on the care plan. Staff interviewed received training during orientation at commencement of employment and annual restraint minimisation and safe practice education is provided.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Pre-restraint/enabler assessment included all of a-h and this is verified in the restraint policy and documentation reviewed. All assessments are undertaken by a registered nurse. The assessment process is developed in partnership with the resident and /or family/whanau or</p>

		other representative as confirmed by one family whose relative has a bedside rail in place. Assessment includes known risk factors such as susceptibility to skin tears and cultural and spiritual requirements.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Approved restraint is only applied as a last resort. The restraint coordinator at interview stated that the service ensures all policies and procedures in place were continually monitored by the restraint approval group as part of the quality management system. Policy is reviewed annually. All restraint is approved prior to use following appropriate assessment processes inclusive of interRAI on admission and are reviewed by the approval group. Monitoring is determined by the identified risk of restraint/enabler use. All restraint/enablers are used for safety reasons only and to maintain independence.</p> <p>The restraint register is established and provided sufficient information to provide and auditable record of restraint use. It identified that enabler use is voluntary and approved and all restraint/enabler use is reviewed and evaluated three monthly.</p> <p>The staff complete a restraint workbook annually and evidence is documented in the individual staff records reviewed.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>The service undertakes an evaluation of all restraint use at a minimum timeframe of three monthly. Family/whanau or a nominated representative was involved in all evaluation processes if consented by the resident. As identified in the restraint policy the resident's right to have a support person is implemented and encouraged by the service. Discussions with family/whanau or support person was documented as part of the evaluation process as sighted. Consent is obtained in writing at all times should a restraint/enabler be continued and if a restraint is no longer required or if it does not appear to be keeping the resident safe as intended the resident, family/whanau would be fully informed of this decision by the restraint coordinator.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint coordinator at interview demonstrated via documentation sighted that three monthly monitoring and annual quality reviews are conducted related to the use of enabler/restraint. Quality review findings inclusive of any trends identified, adverse outcomes, compliance with policies and procedures, safety and appropriateness of restraint use and any recommendations are used to improve service provision and resident safety.</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.

No data to display

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.