

Masonic Care Limited - Horowhenua Masonic Village

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 The DAA Group 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:	Masonic Care Limited
Premises audited:	Horowhenua Masonic Village
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 19 August 2015 End date: 20 August 2015
Proposed changes to current services (if any):	Two bathrooms have been altered to create two new hospital level care bedrooms.
Total beds occupied across all premises included in the audit on the first day of the audit:	72



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Horowhenua Masonic Village provides rest home level and hospital level care for up to 76 residents. The facility is operated by Masonic Village Limited. Residents and families interviewed spoke positively about the care provided.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a nurse practitioner.

Two additional hospital level beds have been notified and agreed to by the Ministry of Health.

There are three improvements required from this audit relating to quality and resident documentation.

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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Staff demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work and caring for residents. Information regarding residents' rights, access to interpreter services and how to lodge a complaint was available to residents and their family. Staff communicate with residents and family members following any incidents/accidents as appropriate. There have been no external investigations since the previous audit.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Masonic Village Limited is the governing body and is responsible for the service provided at this facility. A strategic business plan and quality and risk management systems are fully implemented at Horowhenua Masonic Village and documented scope, direction, goals, values, and mission statement were reviewed. Systems are in place for monitoring the service provided including regular monthly reporting by the village manager to the governing body.

The facility is managed by an experienced and suitably qualified manager. The village manager is non-clinical and is supported by a clinical nurse manager/registered nurse. The village manager and clinical nurse manager are supported by three charge nurses. The clinical nurse manager is responsible for the oversight of the clinical service in the facility.

There was evidence that quality improvement data has been collected, collated and analysed, however there was no documented evidence that data is being reported back to all staff. There is an internal audit programme in place and internal audits have been completed. Corrective action plans have been developed to address areas identified as requiring improvement, however, timeframes for completion, who is responsible for the corrective action, date of close out and review is not documented. Graphs of clinical indicators were available for staff to view along with meeting minutes. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management and current annual practising certificates for health professionals who require them. An in-service education programme is provided for staff and study days are held several times during the year. Staff are also required to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained. Human resources processes were followed.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The clinical nurse manager and charge nurses are rostered on call after hours. Care staff reported there were adequate staff available and that they are able to get through their work. Residents and families reported there were enough staff on duty to provide adequate care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.

Some standards applicable to this service partially attained and of low risk.

Care delivery meets the identified needs of residents and supports the achievement of their individualised goals. An improvement is required relating to short term care plans which do not adequately reflect progress. All other assessments, care plans and evaluation of progress towards identified objectives are detailed, thorough and undertaken in a timely manner. Residents are seen promptly by the doctor/nurse practitioner after admission, reviewed regularly, and referred promptly if their clinical needs change.

The clinical nurse manager and three charge nurses are on site weekdays, with one of these senior staff being available on call at all other times. Registered nurses are on duty 24 hours a day and provide support and guidance to the care giving staff. Verbal and written handovers at the start of each shift, together with the updating of resident progress notes every shift, help promote continuity of resident service delivery.

All aspects of medication management comply with legislative requirements and best practice guidelines. Medications are administered only by registered nurses and enrolled nurses, all of whom have completed medication competency assessments.

An experienced recreation officer coordinates the diversional therapy team which provide a varied activities programme, based on the identified activity needs of each individual resident.

Food service delivery and management complies with legislation and guidelines. The kitchen accommodates a range of individual resident's food likes and dislikes and dietary needs. Residents reported their satisfaction with the food services.

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.

A current building warrant of fitness was displayed. Residents and families described the environment as meeting their or their relative's needs.

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.

Documentation of policies and procedures and staff training demonstrated residents are experiencing services that are the least restrictive. There were residents observed using restraint on the day of the audit.

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 service has a structured and systematic approach to monitoring, analysing and responding to infection rates although the process for informing staff about surveillance results is not as robust. The service uses an external benchmarking organisation for trending information and comparisons are made with other Masonic facilities.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	0	0	0
Criteria	0	38	0	3	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	<p>The village manager is responsible for the management of complaints and the quality coordinator is responsible for maintaining the complaints register. There are appropriate systems in place to manage the complaints processes. The complaints register reviewed evidenced there have been five complaints received for 2015.</p> <p>There have been no investigations by the Ministry of Health, District Health Board, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems were in place that ensured residents and their families were advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Resident meetings are held monthly and residents are able to raise any issues during these meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of the collated resident and family surveys for 2014 evidenced residents and families knew the process for making a complaint.</p> <p>The complaint process and forms were observed to be readily accessible and displayed. Management/RN/staff meeting minutes evidenced reporting of any complaints is an agenda item. Care staff confirmed information was reported to them via their staff meetings.</p>

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the education programme. Staff confirmed their understanding of open disclosure. Communication with family was documented in the residents' progress notes. Incident/accident forms evidenced families were informed when incidents/accidents occurred.</p> <p>Interpreter services are available to residents via staff, family and interpreter services if needed. The village manager advised they have not required interpreter services.</p> <p>Residents and families confirmed communication with staff is open and effective. Care staff were observed communicating effectively with residents during the audit. Residents' files evidenced residents were consulted and informed of any untoward event or change in care provision and this was included in the multidisciplinary reviews of care. Residents and family responded positively concerning effective communication from the resident and family surveys completed in 2014.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>There are established systems in place which define the scope, direction and goals of the organisation, as well as the monitoring and reporting processes against these systems.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service. The village manager provides monthly reports to the governing body. Meeting minutes were reviewed, including management, RN, unit, staff, restraint, infection control and residents' meetings. Meeting minutes were available for review by staff.</p> <p>The facility is managed by a village manager (VM) who is non-clinical and has been in this position for five and a half years. The village manager is supported by a clinical nurse manager who is a registered nurse and was appointed to their current position in 2011. The clinical nurse manager (CNM) is responsible for oversight of clinical care.</p> <p>Review of the two managers' personal files and interview of the village manager evidenced they have undertaken education in relevant areas.</p> <p>Horowhenua Masonic Village is certified to provide hospital level, and rest home level care. On the day of this audit there were 37 hospital level care residents and 35 rest home level care residents. This includes six residents under the 'Occupational Right to Occupy Agreement'. The village manager reported the rehabilitation service has been exited.</p> <p>Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</p>

		The service has contracts with the DHB and Ministry of Health to provide Aged Related Residential Care, Complementary Care Services, a Health Recovery Bed, and Residential Non Aged Service.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	<p>A quality and risk management plan is used to guide the quality programme and includes goals and objectives.</p> <p>The resident family satisfaction surveys were completed and collated in 2014 and results indicated that residents and families were highly satisfied with the services provided.</p> <p>Completed audits for 2014 and 2015, clinical indicators and quality improvement data was recorded on various registers and forms both hard copy and electronically. Quality improvement data was being collected, collated, and comprehensively analysed to identify trends. Benchmarking is also provided by an external agency. Although corrective actions are developed it was difficult to find evidence that they had been implemented. Apart from the health and safety quality data, there was little evidence of documented timeframes for completion, who is responsible for the action, date of completion and evaluation.</p> <p>The village manager provides monthly reports to the trust board. Management//infection control, health and safety, staff, unit and RN meetings are held monthly and minutes were reviewed. The village manager, acting clinical nurse manager and quality manager stated quality data is discussed at the various meetings. There was no documented evidence of reporting of various clinical indicators and quality and risk issues in these meeting minutes. Care staff reported that copies of meeting minutes are available for them to review in the staff areas.</p> <p>A monthly newsletter is produced which keeps residents and families informed with what is happening at Horowhenua Masonic Village.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. Policies / procedures are reviewed by management and are current. Staff confirmed that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p> <p>A health and safety manual is available. The hazard register was current, risks were identified and reported to the health and safety representative who is responsible for the development, implementation, and review of corrective actions.</p>
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or	FA	Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the VM and CNM and signed off when completed. Corrective action plans to address areas requiring improvement were documented on accident/incident forms. Registered nurses

<p>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>undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>There was documented evidence of communication with family and the GP on the accident/incident form and in residents' progress notes following an adverse event and if there is any change in the resident's condition. Residents and family confirmed this. There is an open disclosure policy.</p> <p>Staff confirmed that they are made aware of their responsibilities for completion of adverse events through job descriptions and policies and procedures. Staff also confirmed they are completing accident / incident forms for adverse events. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control).</p> <p>The VM stated they have reported essential notifications to external agencies since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.</p> <p>The clinical nurse manager is responsible for the in-service education programme. The education programmes for 2014 and 2015 were reviewed and education is provided by way of several study days throughout the year and staff are required to attend one of these days. Other education sessions are also held. Individual staff attendance records and attendance records for each education session evidenced ongoing education was provided. Competency assessment questionnaires are current for medication management and restraint management.</p> <p>All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were sighted on staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff confirmed they have completed an orientation, including competency assessments (as appropriate).</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>	FA	<p>There is a documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided 24 hours, seven days a week. On call after hours are provided by the clinical nurse manager and charge nurses. The minimum number of staff on duty is during the night and consists of one RN and three caregivers. The unit that includes the occupational right agreement (ORA) suites has the RN and one caregiver on during the night.</p> <p>The village manager reported staffing levels have been increased in unit 3 where the six occupational right agreement care suites make up a wing of this unit. Registered nurse hours have been increased by 10 hours on the morning shift, and an extra 20 hours on the afternoon shift which covers unit 3 and the other two units. Caregiver hours have been increased by 91 hours per week, cleaning hours increased by 21 hours per week and activities hours increased by seven hours per week. Review of the rosters confirmed this.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. All registered nurses and other staff including those who drive the facility's mobility van have a current first aid certificate. Residents and families reported staff provide them with adequate care.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Registered and enrolled nurses administer all medications in the facility. Records were sighted that all of these staff had been assessed as competent in medication administration. All of the medication charts reviewed contained a current photograph of the resident, allergy status was documented, medications were appropriately prescribed, discontinued medications initialled and dated, three-monthly reviews of medication had been undertaken, and medication administration records were complete. The service is planning to implement the 'MediMap' electronic prescribing system within the next month.</p> <p>Three residents are currently self-medicating. Evidence was sighted of regular evaluation of resident competency related to self-medication, although the service is about to review its processes associated with assessing and ongoing review of self-medication competency. Medication standing orders are not used at the facility. An observation of a medication round confirmed that medications were administered in a safe and appropriate manner.</p> <p>Medications are supplied to the facility using the blister pack system. These packs are checked against the medication chart by a RN (evidence sighted) on arrival to the service. Surplus and expired medication is returned to the pharmacy. The date of first use of eye drops was recorded on those products currently in use. A stocktake of all controlled medication is undertaken weekly.</p> <p>All aspects of medication management complied with legislative requirements and safe practice guidelines.</p>
Standard 1.3.13: Nutrition,	FA	The kitchen caters for a range of nutritional requirements, including diabetic, soft and puree diets. Specialised

<p>Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>crockery and cutlery, such as lip plates and feeding cups, are available to promote residents' independence. A four weekly menu, with summer and winter options, was last reviewed by a registered dietitian in April 2015. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. Residents are weighed monthly and nutritional supplements administered as prescribed. Evidence was sighted of residents being regularly referred to the dietitian who visits the facility fortnightly. Two dining rooms are available for residents or they may have meals in their own room if they wish.</p> <p>On inspection, the kitchen was well maintained, clean and tidy. Food storage complied with all current legislation. Cleaning schedules were sighted. Records were sighted that fridge and freezer temperatures were monitored daily and remained within recommended ranges. Experienced and appropriately qualified staff are responsible for food services within the facility. Resident satisfaction with food is monitored through the annual resident survey, monthly resident meetings and informal feedback from residents. On interview, residents and family members confirmed their satisfaction with food services.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>There was evidence in all residents' records reviewed of regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. InterRAI assessments were current and staff are now focusing their attention on how best to incorporate this assessment information into care planning. Resident progress notes are updated each shift. Registered nurses are on duty 24 hours a day and provide support and guidance for care delivery staff.</p> <p>The nurse practitioner visits the facility at least four times each week and expressed satisfaction with the standard of care provided to residents and with the registered nurse staffing level.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>A recreation officer with 14 years' experience in the role leads the diversional therapy team, which provides both group and one-on-one activities. Residents' previous and current interests are assessed on admission and individual activity plans completed within three weeks and reviewed six monthly, as confirmed in residents' records. These plans help inform the development of the activity programme.</p> <p>Every resident is given a copy of the weekly activity programme with activities also listed on whiteboards around the facility each day. The activities planned for the week of the audit included newspaper reading, exercises, outings in the facility van, church and communion services, entertainment, craft, happy hour, games and movies. The recreation officer also advised that the diversional therapy team work with other local residential care facilities to plan joint activities, such as an upcoming mystery bus tour, as well as dances, games and quizzes. A record is maintained of resident participation in the activities programme.</p> <p>Residents interviewed expressed their enjoyment of the activities programme.</p>

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Low	<p>Resident's long-term nursing care plans are consistently evaluated in a timely and detailed manner, as sighted in all care plans reviewed. The nursing care plans for hospital-level residents are reviewed three-monthly by registered nurses, with six-monthly evaluations for rest-home residents. Evaluations are also completed earlier as clinically indicated. When progress is different from expected, or new clinical issues require addressing, care plans are updated and changes highlighted for staff.</p> <p>There was limited evidence of short term care plans being evaluated in a timely manner. Refer also to Standard 1.3.3.</p>
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	<p>A current building warrant of fitness was displayed at the entrance to the facility that expires 1 June 2016. Since the last audit two hospital bedrooms have been created from two bathrooms. The two bedrooms are spacious and allow staff and equipment to move freely. Both rooms have their own wash hand basin and toilet.</p> <p>The internal and external areas are maintained, safe and appropriate to the resident groups and setting. Residents interviewed confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p> <p>Current calibration/performance verified stickers were observed to be on medical equipment. Current electrical safety tags were on electrical items.</p> <p>The six ORAs care suites have call bells in the bathroom, bedroom and living areas. Residents confirmed call bells are answered in a timely manner. The last fire evacuation was held in the care suites.</p>
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	<p>The service has a structured and systematic approach to monitoring infection incidence. An individual health care-associated infection/incident data sheet is completed for a range of infections, including urinary tract, respiratory, wound, eye, diarrhoea/gastrointestinal, drug resistant and other infections. The infection control coordinator collates the monthly surveillance data, which is then entered into an electronic database, analysed and graphed. Data is also submitted to an external benchmarking organisation, which produces detailed internal trending information for the service. Regular benchmarking is also undertaken with other Masonic facilities.</p> <p>The analysed data is reported to the clinical nurse manager and the village manager, and at the monthly infection control meetings, as confirmed in the meeting minutes. The minutes of these meetings (which all staff are asked to read) do not contain detailed information related to infection results (refer to criterion 1.2.3.6). The infection control coordinator advised detailed surveillance information was shared verbally with</p>

		the qualified nursing staff.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Documented systems are in place to ensure the use of restraint is actively minimised. There were five residents using restraint and one resident using an enabler on the first day of the audit. The restraint coordinator who is a RN reported a multidisciplinary review of all restraint is conducted three monthly. A three monthly report is also sent to the CNM. In-service education relating to restraint and challenging behaviour has been provided to all staff. Restraint usage is an agenda item for the management, staff, unit and RN meetings. Care staff demonstrated good knowledge of restraint and enabler processes. Residents' files evidenced completed documentation relating to restraint and enabler use.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There was evidence both electronically and in hard copy that quality improvement data is collected, collated and analysed to identify trends. Data is provided three monthly by an external agency including benchmarking with other facilities within the group. Various meeting minutes indicated quality data was not being reported back to staff at these meetings. The management team stated data is reported and discussed at these meetings, and RNs confirmed this. However, caregivers reported they are not provided with information relating to collated numbers, trends identified and discussion around corrective actions.	Reporting back to staff on quality improvement data, including clinical indicators and internal audit results, was not evident in the various meeting minutes.	Provide documented evidence that quality improvement data is reported back to staff. 180 days
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order	PA Low	Corrective actions are being developed where deficits have been identified, including internal audits and issues reported at various meetings. However, apart from health and safety documentation, there was no evidence of documented timeframes for completion of the action, who is responsible for the action, date of completion and	There is no evidence that corrective actions developed have been implemented.	Expand the corrective action plan form so that it includes timeframes,

<p>to meet the specified Standard or requirements is developed and implemented.</p>		<p>evaluation.</p>	<p>Corrective action plans do not include timeframes for completion, who is responsible, date of close out and review.</p>	<p>responsibilities, and dates to provide evidence that the corrective action has been implemented and closed out.</p>
<p>Criterion 1.3.8.2 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>	<p>PA Low</p>	<p>With the exception of short-term nursing care plans, residents' service delivery plans, such as nursing care plans and wound care plans, are evaluated in a timely and comprehensive manner. Wound care plans are evaluated at each dressing change and wounds are regularly photographed as part of the evaluation process.</p> <p>The current format of the short-term care plan does not include a space for formal evaluation of progress towards goals. In all four short-term care plans reviewed, there was limited evidence of ongoing evaluation and monitoring of progress towards achievement of goals.</p>	<p>Resident progress towards achieving short-term care goals is not systematically documented and/or evaluated.</p>	<p>Regular and timely evaluations are completed of resident progress towards achieving short-term goals.</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.