

Oceania Care Company Limited - Raeburn Rest Home

Introduction

This report records the results of a Certification 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 Central Region's Technical Advisory Services 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:	Oceania Care Company Limited
Premises audited:	Raeburn Rest Home
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 27 April 2016 End date: 28 April 2016
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:	43

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

General overview of the audit

Raeburn Rest Home (Oceania Care Company Limited) can provide care for up to 54 residents with occupancy at 43 residents during the onsite audit. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management team.

Improvements are required to ensuring that all aspects of the quality and risk programme are discussed at meetings, to training for staff in the dementia unit and to the activities programme.

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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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. This information is brought to the attention of residents' and their families on entry to the service and when requested. Residents and family members confirm their rights are met, staff are respectful of their needs and communication is appropriate.

Consent forms are provided and residents and family are given relevant information. Advance directives are signed by residents deemed competent to complete these. The business and care manager is responsible for management of complaints and a complaints register is maintained.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Oceania Care Company Limited has a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed at head office and quality and risk performance is reported through meetings at

the facility and monitored by the organisation's management team through the business status reports. There is a management system to manage residents' records with a document control process in place. Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. Corrective action plans are documented when issues are identified with evidence of resolution of issues.

There are human resource policies implemented around recruitment, selection, orientation and staff training and development. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

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.
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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the interRAI assessment and the long term care plan are developed over the first three weeks of a resident's admission. Care plans reviewed are individualised and risk assessments completed. Residents' response to treatment is evaluated and documented. Relatives are notified regarding changes in a resident's health condition.

Medicine management policies and procedures are documented and residents receive medicines in a timely manner. The medication management processes and practices are in line with legislation and contractual requirements. The general practitioner completes regular and timely medical reviews of residents and medicines. Medication competencies are completed annually for all staff that administer medications.

The facility utilises four weekly rotating summer and winter menus that are reviewed by a dietitian.

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.

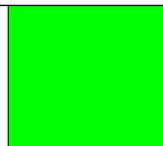
A current building warrant of fitness is in place and New Zealand Fire Service evacuation scheme is approved. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment. There is a secure dementia unit that includes an interactive outdoor area.

Residents' rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place, with regular fire drills completed. Call bells allow residents to access help when needed, in a timely manner.

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.

The restraint minimisation programme defines the use of restraints and enablers. The restraint register is current. During the on-site audit the service used one enabler and one restraint.

Policies and procedures comply with the standard for restraint minimisation and safe practice. Assessment, documentation and monitoring, care planning and reviews are recorded and implemented, and restraint risks are identified. Residents using restraint

had no restraint-related injuries. Staff members receive adequate training regarding the management of challenging behaviour and restraint use.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control is conducted according to the education and training programme and recorded in staff files. The infection control nurse completes monthly surveillance of all infections and collates the information as part of their quality programme.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	47	0	2	1	0	0
Criteria	0	98	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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>Residents state that they receive services that meet their cultural needs, receive information relative to their needs and that staff respect their wishes. Staff are able to explain rights for residents in a way that promotes choice. The posters identifying residents' rights are displayed in the facility.</p> <p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. All staff have had training in 2015. Interviews with staff confirm their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice, including: maintaining residents' privacy; encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</p> <p>The auditors noted respectful attitudes towards residents on the days of the audit.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.</p>

<p>with the information they need to make informed choices and give informed consent.</p>		<p>All resident files identified that informed consent is collected and recorded. Interviews with staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families during the admission process.</p> <p>The policy and procedure includes guidelines on consent for resuscitation/advance directives. Advanced directives in files reviewed are signed by residents deemed competent to complete these.</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>Resident information around advocacy services is available at the entrance to the service and in information packs provided to residents and family on admission to the service. Pamphlets are also available in the service for residents and family to access at any time.</p> <p>Staff training on the role of advocacy services is included in training on the Code and this was last provided for staff in 2015.</p> <p>The Health and Disability advocate visits the service during the year at varying times, as confirmed by the management team.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.</p>
<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>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families interviewed confirm they could visit at any time and are always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friends networks. Residents' files reviewed demonstrate that progress notes and the content of care plans include regular outings and appointments, with a van able to take residents into the community.</p>
<p>Standard 1.1.13: Complaints Management</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>complaint; a description of the complaint; and the date the complaint is resolved.</p> <p>Evidence relating to each lodged complaint is held in the complaint's folder. Two complaints in 2016 were reviewed, indicating that the complaints are investigated promptly with the issues resolved in a timely manner.</p> <p>The business and care manager is responsible for managing complaints and residents and family state that these are dealt with as soon as they are identified. Residents and family members state that they have laid complaints in the past with the management team and they feel that they are listened to with issues resolved.</p> <p>There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit. There is evidence that family can access advocacy services, if they require, to support the complaints process.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The business and care manager, clinical manager or a registered nurse discusses the Code, including the complaints process, with residents and their family on admission. Discussions relating to the Code can also be held at the residents' meetings, as sighted in the meeting minutes reviewed. One family member particularly talked of the focus on maintaining rights for residents in the dementia unit and discussion around how family can support the resident to ensure rights are maintained.</p> <p>The information pack includes information around rights and this can be produced in a bigger font, if required. Information is given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private as described by the managers interviewed. Residents and family members are able to describe their rights and advocacy services particularly in relation to the complaints process.</p> <p>Each resident's room has a handbook which informs residents and families of aspects of care and this includes information around rights and advocacy services.</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>The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Resident's support needs are assessed using a holistic approach. The initial and on-going assessments gain details of people's beliefs and values with care plans completed with the resident and family member. Interventions to support these are identified and evaluated.</p>

		<p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.</p> <p>The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings.</p> <p>Health care assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas, observed on the days of the audit. Residents and families confirm that residents' privacy is respected.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staffs receive annual training on abuse and neglect with this last provided in 2015. Staff can describe signs of abuse and the process for reporting of this. Residents, staff, family and the general practitioner confirm that there is no evidence of abuse or neglect. Staff interviewed were aware of the need for them to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p> <p>Resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified.</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 organisation has a cultural responsiveness policy which outlines the processes for working with people from other cultures. Specifically a Māori health policy outlines how to work with Māori and the relevance of the Treaty of Waitangi. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.</p> <p>Staff who identify as Māori are able to provide support for Māori residents and their families, if needed. Staff report that specific cultural needs are identified in the residents' care plans. The business and care manager has links to the Māori community in Te Aroha and can access support, if required. They state that there is also support through Oceania and from the district health board. This may be to support the service around tikanga protocols or general advice.</p> <p>Staff are aware of the importance of whānau in the delivery of care for the Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<p>The service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>determining when cares occur, times for meals and choices in meals and activities (refer to 1.3.7.1). Health care assistants were observed to actively engage with residents in the dementia unit to identify what they would like to eat from the menu for the following day.</p> <p>Staff work to balance service delivery, duty of care and resident choice.</p> <p>Residents and family are involved in the assessment and the care planning processes as confirmed by residents and family interviewed. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan.</p> <p>Staff are familiar with how translating and interpreting services can be accessed. Residents in the service on audit days did not require interpreting services. There are staff from the Pacific Islands and Asia who can support residents who require cultural support. Interpreting services are also available through the district health board.</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 facility implements the Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed state that they are aware of the policies and are active in identifying any issues that relate to the policy.</p> <p>Residents and family state that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months, relating to any form of discrimination or exploitation.</p> <p>Job descriptions include: responsibilities of the position; ethics; advocacy and legal issues with a job description sighted in staff files reviewed, relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction include standards of conduct. Interviews with staff confirm their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Raeburn Rest Home implements Oceania policies to guide practice. These policies align with the Health and Disability Services Standards and are reviewed bi-annually. Benchmarking occurs across all the Oceania facilities.</p> <p>There is a training programme for all staff and managers are encouraged to complete management training. There are at least monthly regional management meetings with the managers interviewed confirming that they attend.</p>

		<p>Residents and families expressed satisfaction with the care delivered (refer to 1.3.7.1).</p> <p>Consultation is available through the organisation's management team that includes registered nurses, the clinical and quality manager who provided support to the team on audit days, regional manager and a dietitian.</p> <p>The service has focused on projects to improve services with a reduction in the use of restraint over the past year (nine resident using restraint to now only one resident requiring restraint), a focus on reducing challenging behaviour for one resident in particular with success described and a move to a positive environment and peaceful therapy for residents. The service involved external and internal experts to support changes made. The dementia unit has an external environment that encourages engagement with animals and plants.</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>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms.</p> <p>Family contact is recorded in residents' files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and could attend the resident meetings. Family members and residents who attend the resident meetings confirm that they are useful forums to raise issues. The service has also offered training to residents and family, particularly around coming to terms with dementia and family state that this has changed their approach to interaction with their family member. There is an additional focus in the service on providing food for residents in the dementia unit that they can eat at any time and particularly finger food for residents who are constantly mobile. The improvement is designed to support the prevention of weight loss and the treatment of weight loss in the dementia unit.</p> <p>Residents and/or family sign an admission agreement on entry to the service. Those reviewed were signed on the day of admission. The admission agreement provides clear information around what is paid for by the service and by the resident.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned,</p>	FA	<p>Raeburn Rest Home is part of the Oceania Care Company Limited with the executive management team including: the chief executive; general manager; regional manager; operations manager and clinical and quality manager providing support to the service.</p>

<p>coordinated, and appropriate to the needs of consumers.</p>		<p>Communication between the service and the managers takes place on at least a monthly basis. The clinical and quality manager provided support during the audit. The monthly business status report provides the executive management team with progress against identified indicators. The operational and business brief is reviewed as issues identified in the brief have been resolved. There are also monthly reports from clinical specialists employed in Oceania which include a risk spreadsheet for monitoring of resident weight in each facility. This allows the clinical and quality managers to be alerted at the earliest opportunity of any potential resident issues. The clinical and quality manager on the day of audit described reviewing individual care plans to ensure that appropriate individualised interventions are in place.</p> <p>There is a clear mission, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training, provided annually.</p> <p>The facility can provide care for up to 54 residents with 43 beds occupied at the audit. This included 18 residents requiring rest home level care, 12 requiring hospital level care and 13 residents occupying the 18-bed dementia unit. One resident in the hospital was identified as being under the young people with disability contract.</p> <p>The business and care manager is responsible for the overall management of the service. The business and care manager is a registered nurse and has been in the role for 16 months with over 20 years' experience in management of aged care services.</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>In the absence of the business and care manager, the clinical manager is delegated as second in charge with support from the regional operations manager and clinical and quality manager (organisational). The clinical and quality manager confirmed their involvement in supporting the clinical manager if they are in charge along with support from the operational manager.</p> <p>The clinical manager has extensive nursing experience in the military, three years' experience in aged care and has been in the role for 14 months. The clinical manager has held clinical leadership and management positions for over four years.</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</p>	<p>PA Low</p>	<p>Raeburn Rest Home uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews, as required, with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice</p>

<p>principles.</p>		<p>guidelines. A document control system is in place. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to evidence that they have read and understood them. The policy around pressure injuries has been updated, ratified and staff have been informed of the new policy. The registered nurses confirm that they have read and understood the policy.</p> <p>Service delivery is able to be monitored through review of complaints, incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme. The corrective action plans are documented and there is evidence resolution of issues is completed. There is documentation that includes collection, collation, and identification of trends and analysis of data. Internal audits around pressure injuries are completed.</p> <p>There are monthly meetings including: staff/quality improvement; clinical and infection control. There are two monthly resident meetings and restraint meetings. Family are able to come to the resident meetings, if they wish. There is evidence of good attendance by staff at meetings. There are monthly clinical indicator reports with data tabled at meetings. An improvement is required to ensure that there is discussion of issues at meetings and that all aspects of the quality and risk management programme are included at meetings.</p> <p>The satisfaction survey for family and residents in 2015 and 2016 shows that they are satisfied with services provided and this was confirmed by residents and family interviewed (refer to 1.3.7.1).</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly with a facility health check completed by the clinical and quality manager. Any issues are identified, a corrective action plan put in place and evidence of resolution of issues.</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 business and care manager is aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks and changes in key managers. The Ministry of Health and district health board are notified when sentinel events occur.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and are able to describe the importance of recording near misses.</p>

		<p>Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.</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>PA Moderate</p>	<p>The registered nurses, the clinical manager and business and care manager hold current annual practising certificates along with other health practitioners involved with the service.</p> <p>Staff files include appointment documentation including: signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.</p> <p>All staff complete an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Health care assistants confirm their role in supporting and buddying new staff.</p> <p>Annual competencies are completed by clinical staff including: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar and insulin; and assisting residents to shower. Evidence of completion of competencies is kept on staff files.</p> <p>The organisation has a mandatory education and training programme with an annual training schedule documented. Staff attendances are documented for training provided. Education and training hours are at least eight hours a year for each staff member. Three of the seven registered nurses have completed interRAI training and three others are enrolled to complete the course at the earliest opportunity. Staff have completed training around pressure injuries in December 2015 with other training around pressure injuries occurring as part of the manual handling training provided in 2016.</p> <p>Nineteen of the twenty six health care assistants work in the dementia unit. Six have completed training around dementia, nine are currently completing training and have been in the service less than 12 months. There is an improvement required to training for staff in the dementia unit.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably</p>	<p>FA</p>	<p>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meet resident acuity and bed occupancy.</p>

<p>qualified/skilled and/or experienced service providers.</p>		<p>There are 47 staff including clinical staff, a staff member who facilitates the activities programme and household staff. There is always a registered nurse on each shift with a second registered nurse rostered on for at least two shifts a week. The business and care manager and clinical manager are on call. The business and care manager and the rosters confirmed that staff can be brought in for an extra time or to support a resident requiring this, if needed.</p> <p>Residents and families interviewed confirm staffing is adequate to meet the residents' needs.</p> <p>A review of the rosters confirmed that staff are replaced when on leave by casual or bureau staff.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information could be accessed in a timely manner.</p> <p>Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including their designation.</p> <p>Resident files are protected from unauthorised access by being locked away in an office.</p> <p>Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual residents' files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder in the medication room. Staff state that they read the long-term plans at the beginning of each shift and are informed of any changes through the handover process.</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>Residents' entry into the service is facilitated in a competent, equitable, timely, and respectful manner. Information packs are provided for families and residents to the hospital, rest home and dementia unit, prior to admission.</p> <p>The facility requires all residents to have needs assessment service coordinators (NASC) assessments prior to admission, to ensure they are able to meet the resident's needs. Interviews confirm that the registered nurses (RNs) admit new residents into the facility. Evidence of completed admission records was sighted. The RNs receive handover from the transferring agency, for example, the hospital and utilise this information in creating the appropriate initial care plan and after three weeks, the person centred care plan, for the resident. The clinical manager is</p>

		responsible for the management of entry to the service.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family. There are documented policies and procedures to ensure exit, discharge, or transfer of residents are undertaken in a timely and safe manner. The CM reported that they include copies of the resident's records including: GP visits; medication charts; current long term care plans; upcoming hospital appointments; and other medical alerts, when a resident is transferred to another health provider.</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>Medicine management policies and procedures are in place and implemented, including processes for safe and appropriate prescribing, dispensing and administration of medicines. The medication areas are free from heat, moisture and light, with medicines stored in original dispensed packs, in a secure manner.</p> <p>Medicine charts list all medications the resident is taking, including name, dose, frequency and route to be given. All entries are dated and allergies recorded. All residents have photo identification. Discontinued medicines are identified. Three monthly GP reviews were completed within the three monthly timeframe and medicines charts were reviewed. Medication reconciliation policies and procedures are implemented. Medication fridge temperatures are monitored daily.</p> <p>Controlled drugs are kept inside a locked cupboard and the controlled drugs register is current and correct. Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy. Medication administration was observed during lunch time in the dementia unit and hospital. The staff members checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines, and then signed off after the resident took the medicines.</p> <p>Staff are authorised to administer medications, competencies were reviewed by the lead auditor on the days of audit. This requires completion of medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies. There was one resident who self-administered inhalers. The resident, who self-administers medicine, completes competency checks, has RNs check and record that medicines were taken and the resident has a secure storage area for safe keeping of their medication. Medicines management training occurs for staff.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service policies and procedures are appropriate to the service setting, with seasonal menus reviewed by a dietitian. Residents' dietary profiles are developed on admission, and reviewed six monthly, or when a resident's condition changes. There are current residents' dietary profiles in residents' files and copies in the kitchen. The service employs the services of a chef. Kitchen staff are informed if resident's dietary requirements change. Interviews with kitchen staff confirm their awareness of the residents' dietary requirements. Kitchen staff are trained in safe food handling processes. Food safety procedures are adhered to.</p> <p>The service is focusing on providing food for resident in the dementia unit that they can eat at any time. The provide finger food for residents who are constantly mobile. This practice is to support the prevention of weight loss and the treatment of weight loss in the dementia unit.</p> <p>Residents who require special dining aids are provided for, to promote independence. The residents' files demonstrate monthly monitoring of individual resident's weight. The service implements short term care plans for residents who lose two kilograms or more within one month. Supplements are provided to residents with identified weight loss. In interviews, residents stated they are satisfied with the food service. Residents reported their individual preferences are met and adequate food and fluids are provided. The residents' meeting minutes' evidence feedback about the food service is positive. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply 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>Raeburn Rest Home has a documented process for the management of declining residents' entry into the facility. Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services. The scope of services provided is identified in the admission agreement and communicated to prospective residents and their families; this was confirmed during interviews with residents and their families.</p> <p>The clinical manager (CM) assesses the suitability of residents and uses an enquiry form with appropriate questions regarding the specific needs and abilities of each resident. When residents are not suitable for placement at the service, the family and or the resident are referred to other services, depending on their level of needs.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely</p>	<p>FA</p>	<p>The RNs or the clinical manager (CM) complete a variety of risk assessment tools for residents on admission to the facility. Trained nurses complete interRAI assessments for new residents. Additional assessments were sighted in the residents' files, including the medical assessment completed by the GP and recreational assessment completed by the activities coordinator (AC)</p>

manner.		<p>(refer to 1.3.7.1). Baseline recordings are recorded for weight management and vital signs with monthly monitoring.</p> <p>The needs, support requirements, and preferences are collected and recorded for residents. Staff interviews confirm that the families are involved in the assessment and review processes. The outcomes of the assessments are used in creating an initial care plan, the long term care plan, and a recreational plan, for each resident.</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 person centred care plans (PCCP) are resident focused and integrated. Interventions sighted were consistent with the assessed needs and best practice. Goals are realistic, achievable and clearly documented. The service records intervention for the achievement of the goals.</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>Residents' receive adequate and appropriate services meeting their assessed needs and desired outcomes refer to 1.3.7.1). Interventions are documented for each goal in the PCCPs. Multidisciplinary meetings are conducted to discuss and review long term care plans. Residents' files reflect residents and family involvement in the development of goals and review of care plans.</p> <p>Interview with the GP confirmed clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long term care plans such as: the physiotherapist; the dietitian and needs assessment service coordinators (NASC).</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>	PA Low	<p>The activities programme confirms that independence is encouraged and choices are offered to residents. The activities coordinator (AC) develops and implements the activity programme with oversight of a diversional therapist from another facility nearby. On admission, the AC completes a recreation assessment and an activities plan for each resident. Resident meeting are held monthly (refer to 1.2.3.5). The residents in the dementia unit have 24 hour challenging behaviour plans in place to assist with the management of challenging behaviour, when it occurs.</p> <p>Although activities include: physical; mental; spiritual and social aspects of life, family interviews and observation during the onsite audit confirmed that implementation of the activity programme was not meeting the needs of all the residents. The assessment records showed that past and present activities and interests were not comprehensively documented and residents from the hospital and dementia unit, who were not able to attend activities in the rest home lounge, did not have appropriate activities meeting their specific needs. Residents' files reviewed during the onsite audit had six monthly activity reviews completed. The service had one younger resident</p>

		who had additional activities meeting their social needs.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The residents' files reviewed showed long term care plans had six monthly reviews completed. Clinical reviews are documented in the multidisciplinary review (MDR) records, which include input from the GP, RNs, HCAs, the AC and other members of the allied health team. Progress notes are completed at every shift by the HCAs and RNs. Progress notes reflect response to interventions and treatments. Residents are assisted in working towards goals. Short term care plans are developed for acute problems, for example: infections; wounds; falls; and other short term conditions.</p>
<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>The CM stated that residents are supported in access or referral to other health and disability providers. The RNs manage referrals for residents to the GP; dietitian; physiotherapist; speech language therapist and mental health services. The GP confirmed involvement in the referral processes. The review of residents' files included evidence of recent external referrals to the physiotherapist and specialists.</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>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation, including the requirement for labels to be clear, accessible to read and are free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of protective clothing and equipment that is appropriate to the recognised risks, for example: goggles/visors; gloves; aprons; footwear and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p>	FA	<p>A current building warrant of fitness is displayed – expiry date June 2016. There have been no</p>

<p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>building modifications since the last audit although there has been refurbishment of rooms.</p> <p>There is a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment annually. Interviews with staff and observation of the facility confirm there is adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy, when required. There are courtyards and grass areas with shade, seating and outdoor tables.</p> <p>There is a secure dementia unit that includes an outdoor area with seating and shade, paving and grass areas. Residents were encouraged to access outdoor areas.</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>There are adequate numbers of accessible toilets/bathing facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members report that there are sufficient toilets and showers.</p> <p>Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified, with the ability to have privacy.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for both the equipment such as hoists, at least two staff and the resident, ability to include emergency equipment in the room, if required.</p> <p>Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.</p> <p>There is room to store mobility aids such as walking frames in the bedroom safely during the day and night, if required.</p> <p>Four bedrooms were identified as dual purpose in the rest home/hospital area. All dual purpose beds were occupied by residents requiring rest home level care on the day of the audit. Staffing</p>

		<p>was appropriately provided to meet their needs and the ability to support residents as well as to engage residents socially was considered when identifying the best fit for resident and bedroom.</p> <p>Each resident has their own bedroom although there are rooms large enough to accommodate two residents. These are only used for two residents if there is a couple who request to share a bedroom.</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>	FA	<p>The service has lounge/dining areas, including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely.</p> <p>The dining areas have ample space for residents. Residents can choose to have their meals in their room. Some residents who require support for eating are able to eat in a lounge area in reclining chairs as per their individual needs.</p> <p>There is a lounge and dining area in the secure dementia unit.</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>	FA	<p>Laundry is completed off site with covered laundry trolleys and bags in use for transport. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the rooms. Residents and family members state that the laundry is well managed and there are few complaints or incidents documented around misplaced laundry. The laundry staff interviewed confirmed knowledge of their role, including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the cleaning trolley must be with them at all times.</p> <p>All chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning and laundry processes are monitored through the internal audit process with no issues identified in audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and</p>	FA	<p>An evacuation plan was approved by the New Zealand Fire Service in April 2010. An evacuation policy on emergency and security situations is in place with this localised to the region. A fire drill is provided to staff six monthly. The orientation programme includes fire and security training. Staff</p>

<p>timely response during emergency and security situations.</p>		<p>confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member with a first aid certificate on duty, as confirmed through review of training records and rosters.</p> <p>All required fire equipment was sighted on audit days and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including: food; water; blankets; emergency lighting and gas BBQs.</p> <p>An electronic call bell system utilises a pager system. Staff in the dementia unit and a staff member in the rest home/hospital carry walkie-talkies and this has improved the ability of staff to access support if needed. There are call bells in all residents' rooms, residents' toilets, and communal areas, including the hallways, lounges and dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening that confirms that security measures have been put in place.</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>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature.</p> <p>There is a designated external smoking area for residents and this is away from resident areas.</p> <p>Family and residents confirm that rooms are maintained at an appropriate temperature with heat pumps and panel heaters when required.</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>	<p>FA</p>	<p>The responsibility for infection control (IC) is clearly defined and there are clear lines of accountability for IC matters in the facility. The IC committee has representatives from each area of the service management team. This group meets monthly. There is an IC programme that was last reviewed in August 2015.</p> <p>When a resident presents with an infection, staff send specimens to the laboratory for sensitivity testing. The GP prescribes antibiotics as per sensitivity, confirmed during interview. The RNs create short term care plans and review the effectiveness of the prescribed antibiotics when the treatment is completed. Infections are discussed during staff meetings, sighted in meeting minutes</p>

		(refer to 1.2.3)
<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>	FA	There are adequate human, physical, and information resources, to implement the IC programme and meet the needs of the organisation. Hand washing signs were sighted around the facility to remind staff and residents of the importance of proper hand washing. The facility maintains regular in-service training for IC, including standard precautions, personal protective equipment, cleaning, infectious diseases and hand washing. Sighted training records are aligned with the training planner.
<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>	FA	Documented policies and procedures for the prevention and control of infection reflect accepted good practice and relevant legislative requirements and are readily available and implemented at the facility. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	The organisation provides relevant education on IC to all service providers, support staff, and residents. The IC education is provided by the clinical manager (CM) who is the infection control nurse (ICN) or external resource speakers. Residents interviewed were aware of the importance of hand washing. Staff members confirmed receiving IC training and could explain the importance of hand washing in the prevention and control of infection. The ICN produced a short film on the prevention of infection, including hand washing methodology and the correct way to use personal protective equipment.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been</p>	FA	The clinical manager (CM) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.

specified in the infection control programme.		<p>Information gathered is clearly documented in the infection log maintained by the CM/ICN. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the IC programme. IC processes are in place and documented.</p> <p>The organisation has an internal benchmarking system. Infections are investigated and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meeting. There has been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Staff interviews, observations, and review of documentation, demonstrated safe use of restraint and enablers. The service has a policy of actively minimising restraint. The service has a documented system in place for restraint and enabler use, including a current restraint register. There was one restraint and one enabler being used in the facility on audit days. The restraint coordinator is the clinical manager.</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>The facility maintains a process for determining approval of all types of restraints used. The restraint coordinator completes a restraint assessment, which is then discussed with the GP prior to commencement of any restraint. The restraint committee is defined in the restraint minimisation and safety policies and procedures.</p> <p>The duration of each restraint is documented in the restraint plans of residents. Health care assistants are responsible for monitoring and completing restraint forms, when the restraints are in use. Evidence of ongoing education regarding restraint and challenging behaviour is evident. This was confirmed during staff interviews.</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>Restraint assessments include restraint related risks. The service records underlying risks that contribute to the resident requiring restraint. This focus on culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Before resorting to the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury, for example, the use of sensor mats. Restraint consents are signed by the GP, family and the restraint coordinator. Restraints are incorporated in the long term care</p>

		plans and reviewed three monthly. The restraint register is up to date. The CM confirmed that the facility uses restraints safely.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint related injuries and whether the restraint is still required. The families are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The facility demonstrates the monitoring and quality review of their use of restraints. The audit schedule was sighted and included restraint minimisation reviews. The content of the internal audits includes the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice was also included in the quality reviews.

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 1.2.3.5 Key components of service delivery shall be explicitly linked to the quality management system.	PA Low	There are a range of meetings held that include all staff at relevant meetings. Staff sign to state that they have attended the meeting and the meeting minutes are left in the staffroom for other staff to read. Most aspects of the quality and risk management programme are included in the meeting minutes with some evidence of discussion around the data tabled. Monthly indicator reports table data with a narrative around the result documented. The clinical and quality manager states that there has been discussion of having a set agenda for meetings that would help to ensure that all aspects of the quality and risk management programme is discussed.	The meeting minutes and monthly facility reports do not evidence discussion around all aspects of the quality and risk management programme, including clinical indicators and human resources.	Ensure that meetings held include all aspects of the quality and risk management programme, with discussion of data at meetings. 90 days
Criterion 1.2.7.5	PA	There is a training plan with all staff having had	The nine staff who have received the training	Ensure that

<p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>Moderate</p>	<p>training around dementia and challenging behaviour in the past year. There are six staff members who have completed their external training in dementia with a sample of three certificates sighted confirming this. There are nine staff enrolled in the dementia programme (Oceania course that is provided through a tertiary provider) and they have been in the service for less than 12 months. Four staff have not completed training however they only provide cover when others are on leave in the dementia unit.</p> <p>The spreadsheet confirmed by the business and care manager as being accurate lists the staff who have completed training and the staff enrolled. While staff in training have completed the modules, they are not enrolled with the Oceania programme and therefore are not listed on the course.</p>	<p>packs for dementia and who have completed part or most of the training have not been formally enrolled in the programme with Oceania.</p>	<p>staff who work in the dementia unit receive and complete training as per the requirements of the Oceania programme.</p> <p>90 days</p>
<p>Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>The activities coordinator completes service specific activity programmes for the hospital, rest home and the dementia unit. Assessments are completed which include past and present interests and activities. Activities include cognitive, physical and social aspects of living and the programme also provides group and individual activities. Activities are voluntary for residents. Documentation of assessments and individual activity planning is minimal and the implementation of the overall programme is currently not working well.</p>	<p>i) Documentation of assessments and individual activity planning is not comprehensive and does not clearly reflect the personal choices and abilities of the residents.</p> <p>ii) The overall activities programme is not currently working well as the majority of activities are held in the rest home lounge. Residents from the hospital and dementia unit who are mobile and able to attend these activities do so, under supervision. However the residents in the hospital and dementia unit who are not able to attend communal activities in the rest home lounge have background music played to them. Very few activities are offered to this group of residents especially when activities for those that are mobile are conducted in the rest</p>	<p>i) Activity assessments and past and present interests (as part of the planning process) should be clearly documented and person specific.</p> <p>ii) Activities for the residents in the hospital and the dementia unit, who are not</p>

			home.	<p>able to attend the activities in the rest home lounge should be implemented throughout the day,</p> <p>the activities should be according to the written activities programmes, prepared for these areas of care, should be varied and promote resident participation (not just having music playing in the background).</p> <p>90 days</p>
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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.