

Cantabria Home and Hospital Limited

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).

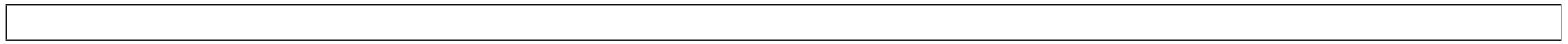
The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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:	Cantabria Home and Hospital Limited
Premises audited:	Cantabria Home and Hospital
Services audited:	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Dementia care
Dates of audit:	Start date: 4 August 2016 End date: 5 August 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:	161



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

Cantabria Home and Hospital is a privately owned facility. It is one of a group of three facilities operating and owned by the same company.

The facility has 176 bedrooms, 60 which can be used as double rooms but the service currently only uses all bedrooms for single occupancy. They offer rest home care (including dementia care), hospital care and residential disability care.

This surveillance audit has been undertaken to establish compliance with the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, a family member, management, staff and a general practitioner (GP).

There were ten areas identified for improvement from the previous surveillance audit which have all been addressed and are now fully attained. There are two areas identified for improvement from this audit related to interRAI assessment timeframes and behaviour management charts in the dementia unit not meeting the district health board contractual requirements.

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.

Communication with residents is open and honest and reflects the service's open disclosure policy. The service implements processes for contacting interpreting services when this is required.

The service has a complaints management system in place which meets the standard and legislative requirements. At the time of audit there are no outstanding complaints.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.

Standards applicable to this service fully attained.

Cantabria Home and Hospital has an up to date business plan which covers all aspects of service delivery planning. The business plan is reviewed annually at senior management level to ensure service planning and coordination meets the needs of residents.

The senior management team consists of the owner/director, finance and development manager, administration manager, human resources manager, purchasing manager and the three nurse managers from each of the facilities owned and operated by the organisation. Members of the team are all experienced in the roles they undertake. The nurse manager at Cantabria Home and Hospital is a registered nurse and has overall day to day responsibility for service management with support from the project support advisor, health and safety and infection control coordinator, residential liaison nurse and a team of clinical registered nurses.

The service has quality and risk management systems which are understood by staff. Quality management reviews include an internal audit process, complaints management, incident/accident, and restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff and residents and family/whānau as appropriate. Corrective action planning occurs as required. Good human resources practices are implemented. The staffing skills mix is appropriate for the level of care and services provided. Every shift is covered by a registered nurse and at least one staff member who holds a current first aid certificate.

As confirmed during resident and family/whānau interviews, the services provided meet residents' 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.

The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. The organisation has implemented the required electronic assessment tool and implements interventions to achieve the resident's desired outcomes and goals. The care plans reflect the assessed needs of the resident and are evaluated at least six monthly or sooner if there is a change in needs.

The service provides a planned activities programmes to develop and maintain skills and interests that are meaningful to the resident. This includes the younger people at the service and residents living in the secure dementia unit.

A safe medicine management system was observed. Processes and procedures around storage, medication charts and ensuring ongoing staff competence reflect legislation and current best practice.

The residents' nutritional requirements are met by the contracted service provider and preferences and special diets can be catered for. All staff who prepare meals are experienced, with meals prepared from a rotating summer and winter menu plan, approved by a registered 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.
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The building has a current building warrant of fitness. There have been no changes made to the building footprint since the previous audit.

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.
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There are eight restraints and five enablers in use at the time of audit. Policy describes enablers as being voluntary. Restraints and enablers are only used for safety reasons. The restraint register is up to date and easy to follow.

Staff education related to restraint minimisation occurs during orientation and is included in the annual education planning process.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control management programme, inclusive of surveillance, is appropriate for the nature of this service. The registered nurse who is the infection control co-ordinator collates monthly surveillance data and reports to the nurse manager. Where there are any trends identified action is implemented. The infection surveillance results are reported at management, quality and staff monthly meetings. Expertise is available and can be sought as required.

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	1	1	0	0	0
Criteria	0	37	1	1	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>Complaints management is implemented to meet policy requirements. The complaints register sighted was up to date and identifies that at the time of audit there are no open complaints. All complaints are fully investigated by the resident liaison nurse and results are informed to the complainant within a set timeframe.</p> <p>The manager confirmed complaints management information is used as an opportunity to improve services as required. One example relates to the use of a pain assessment tool being introduced as part of clinical care. This was sighted in resident files during the file review audit.</p> <p>Complaints processes are explained during the admission process as confirmed during resident and family/whānau interviews.</p> <p>One Health and Disability Commissioner's complaint which was open at the previous audit is now closed (21 August 2015) with both suggest improvements being implemented.</p> <p>Staff verbalised their understanding and correct implementation of the complaints process. Complaints are a standing agenda item for staff and management meetings.</p>
Standard 1.1.9: Communication	FA	The families of residents interviewed confirmed that they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure is documented in the family communication

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>sheets, on the accident/incident form and in the residents' progress notes. The service promotes an environment that optimises communication through the use of interpreter services as required and staff education related to appropriate communication methods. Some residents do not have English as their first language, with effective communication being maintained by staff and family/whānau who speak the resident's language. Policies and procedures are in place if interpreter services need to be accessed.</p>
<p>Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Policy is in place and implemented related to business and quality planning. The organisation's vision, mission statement, values, organisational structure and scope of service are clearly documented. The business plan is reviewed annually by the management team and advisory board consisting of the owner/director, finance and development manager, administration manager, purchasing/maintenance manager, project manager and nurse manager from the three facilities operated by the same company. The business plan has been updated for the 2016 year. Goals and objectives are documented and they cover all aspects of service delivery. The people responsible for ensuring the goals are met was identified and key performance indicators are in place. The management and advisory board meet four monthly and monitor the degree to which each goal is progressing. Quality and risk planning details show the risks, current controls and ongoing actions taken to limit risk.</p> <p>On the day of audit, there were 48 hospital level care residents, including six residential disability residents, and 113 rest home level care residents, which included eight secure dementia care and seven residential disability residents. There are two boarders who are not included in the audit.</p> <p>The nurse manager has overall responsibility for the day to day management of the facility and she is supported by the members of the management and advisory board and a team of registered nurses. Members of the management team attend professional education forums to ensure their skills and knowledge are maintained. The job descriptions sighted identify the authority, accountability and responsibility related to the role each person undertakes.</p> <p>Interviews with residents and family/whānau members confirmed management operate an open door system and that they can speak with a member of the team when they wish. No negative comments were made regarding services provided.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and</p>	FA	<p>Staff confirmed during interview that the quality and risk management systems documented are understood and implemented during service delivery. These processes include regular internal audits, incident and accident reporting and analysis, health and safety monitoring, infection control management and data recording and complaints management processes. If an area of deficit is found, corrective measures are put in place to address the situation. For example, as the result of one complaint follow up it was discovered that not all staff understood the abbreviations used by district health board staff when a resident was discharged. This has resulted in the</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>facility now gaining a copy of the abbreviations and education being undertaken so staff understand and use the same abbreviations. As observed, a list of these abbreviations are available at all nurses' stations.</p> <p>All quality data collected is shared with staff as sighted in meeting minutes and confirmed during staff interviews. The quality data results are reported to staff in a manner that is easily understood and shows comparisons from previously collected data. Quality data information is used by management to inform ongoing service planning and to ensure residents' needs are being met. Corrective measures put in place are evaluated during monthly staff meetings.</p> <p>Residents' meetings, annual multidisciplinary meetings for individual residents and satisfaction surveys are all forums used to indicate resident satisfaction of services offered. All service delivery issues are discussed and followed up as required. Staff verbalised quality improvements and how they have been embedded into everyday practice. One example relates to food service audits which identified that resident dissatisfaction with the menu. This was fully reviewed by a dietitian with input from the kitchen supervisor and upgraded menus were put in place in April 2016. The nurse manager stated that verbal feedback from resident meetings and documented feedback in the food feedback diaries located in all dining areas has been positive. A full review of the food services will be conducted in November 2016.</p> <p>Policies and procedures are maintained by the management group and the process implemented ensures that they are kept up to date. Staff can access hardcopies of policies and procedures at any time.</p> <p>Actual and potential risks covering all aspects of service provision are identified and documented along with the hazard register. These documents are monitored by the health and safety committee with representatives from across the spectrum of the workforce. Newly identified hazards are documented and reported to management, staff, residents and visitors as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes.</p> <p>Residents and families/whānau interviewed confirmed they are happy with the services provided.</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</p>	<p>FA</p>	<p>Policy is implemented by the service in relation to reporting, recording and monitoring adverse events. The service records all incidents and accidents on a specific form. Any follow up required is undertaken in a timely manner and outcomes are monitored by management. Staff interviewed confirmed they report and record all incidents and accidents.</p> <p>Documentation confirmed that information gathered from incidents and accidents are used as an opportunity to improve services where indicated. Incident and accident information is reported at staff monthly meetings and reviewed along with all related data at three monthly health and safety committee meetings as confirmed in minutes sighted. The review of residents' files contained a specific documented family/whanau documentation section which identified who was informed of any event or concerns. This was also confirmed during interviews</p>

<p>and where appropriate their family/whānau of choice in an open manner.</p>		<p>with family/whānau members.</p> <p>The members of the management team confirmed their understanding related to the obligations in relation to essential notification requirements including pressure injury reporting under Section 31 of the Health and Disability Services (Safety) Act 2001. Reports were sighted for an infection control outbreak and pressure injuries. One sudden death (13 October 2015) was lodged as a coroner's inquest and discharged with no follow up required on 30 March 2016. (Section 31 notification sighted).</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>	FA	<p>Policies and procedures identify human resources management practices that reflect good employment practice and meet the requirements of legislation are implemented by the service. Job descriptions clearly described staff responsibilities and accountabilities. The 20 staff files reviewed showed that staff have completed an orientation programme with specific competencies for their roles. Staff annual appraisals are up to date.</p> <p>There is an annual education calendar in place for on-site education which is undertaken. This covers all aspects related to service delivery and care provision. Education included regular staff attendance at off-site presentations and all staff confirmed during interview that they are supported and encouraged to undertake a wide range of education. On-site education is offered multiple times to ensure staff from all areas and all shifts can attend. Compulsory education attendance, such as restraint, is monitored to ensure all staff have completed this once a year. The registered nurses and enrolled nurses have their educational hours monitored by the educator to ensure they meet the professional development hours required to meet the requirements of the Nursing Council of New Zealand in regards to maintaining their annual practising certificates.</p> <p>The healthcare assistants are encouraged to undertaken recognised aged care educational papers. All healthcare assistants who work in the dementia unit hold dementia series qualifications. This is identified on rosters reviewed and in staff file reviews.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted. This includes 18 staff who hold competencies in interRAI assessments. The nurse manager is interRAI trained but does not hold an up to date competency.</p> <p>Resident and family/whānau members interviewed identified that residents' needs are met by the service in a professional manner.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	FA	<p>Policy related to staff skill mixes and experience is reflected in the roster and meets contractual requirements. Every shift is covered by a RN and at least one staff member with a current first aid certificate.</p> <p>A review of the roster showed that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed they have adequate staff on each shift to allow all tasks to be completed in a timely manner and that</p>

timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.		<p>residents' needs are met. This is supported by resident and families/whānau interviewed. There are dedicated dementia care staff rostered to the unit.</p> <p>Senior members of the management team including the nurse manager work Monday to Friday and are on call. There are dedicated kitchen, laundry and cleaning staff. Activities staff work six days a week.</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>Medication improvements identified in the previous audit related to documentation, controlled drugs charts not reflecting current best practice, and not all staff having current medication competencies have all been addressed.</p> <p>The observed medication procedures are implemented to meet legislative and best practice requirements. The medications are stored in the locked medication trolley and locked medication or treatment rooms. Medications that require refrigeration are stored in a medication fridge, with the temperatures within the required range at most recordings. There were two readings that were above the required range and the service implemented actions to reduce the temperature of the fridge. The processes for controlled drug management meet requirements.</p> <p>There are residents who self-administer their medications, with these files sampled evidencing the resident is assessed as competent to do so. All staff who administer medications are assessed as competent to do so.</p> <p>The medications are delivered by the pharmacy in a pre-packed administration system. These medication packs and the signing sheets are checked for accuracy by the RN. The medication charts and prescriptions have the required information and are either hand written by the GP or a pharmacy generated medication chart that is signed by the GP. The three monthly medication reviews are recorded in the resident's file and not on the medication chart.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>Food, fluid and nutritional needs of residents are provided in line with the menu approved by a qualified dietitian in March 2016. This covers both a summer and winter menu. The introduction of the updated menu for 2016 followed dietitian suggestions such as fortifying porridge with whole milk to increase calcium intake. The dietitian is available on a referral basis.</p> <p>All residents have a dietary assessment upon entry to the service and this is updated at least six monthly. A copy of the most current dietary assessment is kept in the kitchen so that all staff are aware of residents' nutritional requirements. Additional or modified nutritional requirements or special diets are catered for by the service. For example, one resident does not have pork due to religious reasons. Specific dietary information is clearly shown on large white boards in each of the two main kitchens.</p> <p>The food is prepared in two main kitchens, one in each of the two care facility buildings on site and four satellite kitchens throughout the facility for ease of accessing additional drinks and snacks over a 24-hour period. A qualified chef is employed in each kitchen area and there is a nominated service manager to oversee and facilitate</p>

		<p>the overall food service. All kitchen staff have undertaken safe food handling education as confirmed in staff files reviewed.</p> <p>Food is transported to each care dining area via a Bain Marie or covered trays. The care staff serve meals and assist residents as required. The kitchen staff monitor leftover food as a method of ensuring the menu is suitable for residents. Choices are available on a daily basis to meet resident likes and dislikes. The menu is displayed daily. Policies and procedures and guidelines are available. Additional foods are available at all times.</p> <p>Food procurement, production, preparation, storage, transportation, delivery and disposal of the food service complies with current legislation and other requirements. Foods are rotated to ensure older food is used first, and all fridge and freezer temperatures are recorded daily and remain within identified ranges. Daily and weekly cleaning tasks are undertaken by kitchen staff to meet procedural requirements. The kitchens have been refurbished over the past 12 months and staff confirmed they have adequate equipment to maintain the service.</p> <p>Residents confirmed their satisfaction with food services during interview.</p>
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	<p>The documented interventions are not consistently recorded to a level of detail that provides clear strategies for each individual resident. The care plans and interventions are based on the outcomes from the assessments and the identified needs of the resident. The care plan format includes the resident's specific needs, goals/aims and staff interventions required to address those needs. The care plans evidenced family consultation and input into their planning. Care was observed to be flexible and focused on promoting quality of life for the resident's. The residents and family/whanau reported satisfaction with the care and with specific management of their relative's medical conditions.</p>
Standard 1.3.7: Planned Activities 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.	FA	<p>The previous audit identified that the activities programme had limited aged specific activities provided for the younger disabled residents under the age of 65. This is now addressed.</p> <p>The residents are included in meaningful activities at the care facility, this includes younger people and the residents living in the dementia unit. There is an activities coordinator seven days a week. The activities staff reported that they gauge the response of residents during activities and modified the programme related to the response and interests. The activities are modified according to the capability and cognitive abilities of the residents. A number of the younger people are involved in activities in the community and with family/whanau.</p> <p>The activities programme covers physical, social, recreational and emotional needs of the residents. The residents were observed to be participating in meaningful activities both inside and out in the grounds of the service. The residents and families reported overall satisfaction with the level and variety of activities provided. Residents were</p>

		observed to be going offsite with family/friends.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	<p>The previous audit identified that not all temporary needs are documented in short term care planning. This is now addressed.</p> <p>Evaluations are conducted at least six monthly and recorded on the care plan. The service has processes in place to use the built in evaluation scores when the service reassesses the resident using the interRAI assessment and record this on their own paper based evaluation record. The current care evaluations are conducted for all the residents' needs and recorded how the resident's goals have been met over the past six months.</p> <p>When there are changes in the resident's needs, the service uses a short term care plan to capture these changes. The short term care plans identify the need, interventions and evaluation of the interventions. If the issue then becomes a long term need, these are then recorded and updated on the long term care plan.</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	The buildings have a current building warrant of fitness which expires on 31 July 2017. Monthly building compliance documentation was sighted. There have been no changes to the foot print of the facility since the previous audit.
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>Cantabria Home and Hospital oversee all infection control management via a joint infection control and health and safety committee. The surveillance data collected is appropriate to the size and services offered. Monitoring occurs for any urinary infections, eye infections, upper and lower respiratory infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections as required.</p> <p>All staff participate in the collection of infection control data and 'wing leaders' record each infection. The infection control coordinator (RN) gathers the information monthly and this is trended against previously collected data and benchmarked against the organisation's other two sister facilities. If the monthly surveillance report identifies any trends corrective actions are put in place. This occurred in July 2016 when there was a spike in respiratory infections. Follow up included additional staff education to remind staff about hand hygiene, keeping the environment clean, cough etiquette, social distancing, clean uniforms daily, use of personal protective equipment and standard precautions. A monthly infection control theme is presented at each staff meeting and additional staff infection control education is presented throughout the year.</p>

		Infection control surveillance results are reported to management and staff at the various meetings held as confirmed in meeting minutes sighted. Infection prevention and control is connected to the risk management programme. There has been one infection outbreak since the previous audit, which occurred in March 2016. It was contained within the dementia care unit and only one staff member was involved. Public health notifications and reports were sighted, as required.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Enablers are described in policy as being voluntary and the least restrictive option to keep residents safe whilst promoting or maintaining independence. There were five enablers and eight restraints in use at the time of audit. These are clearly documented in the restraint register. The restraint committee meets three monthly and the meeting minutes sighted for July 2016 identifies that every resident with restraints or enablers were fully reviewed. One restraint file and one enabler file reviewed identified that all processes had been undertaken to meet safe restraint practice. Restraint and enabler use is identified on care plans with monitoring requirements identified. Staff education related to restraint occurs during orientation and annually thereafter. This is confirmed during staff interview and in staff education records sighted.

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 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Negligible	All of the files did have an interRAI assessment. The care protocols, assessment summary and outcomes have been included in the care plan. Three of the residents' files reviewed, of residents admitted in 2016, did not have an interRAI assessment evidenced within 21 days of admission. The organisation's records evidenced that the service did not gain access to these assessments till after 21 days. The service attempted to gain access to the interRAI within the first 21 days and have copies of email communication with the needs assessment service to ask for access to the records. The service has completed the assessments within three days of receiving access to the overdue interRAI. If there were any other needs identified from these assessments, the care plans were updated accordingly.	The three resident files reviewed with admissions in 2016 did not have an interRAI assessment completed within 21 days.	Provide evidence that interRAI is released within 21 days of admission. 90 days
Criterion	PA Low	In the secure dementia unit, the residents' files had limited evidence of	The two of	Provide evidence that the

<p>1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>		<p>prevention-based strategies for minimising episodes of challenging behaviours; a description of how the behaviour of the resident is best managed over a 24-hour period or a description of the activities that meet the resident's needs in relation to individual diversional, motivational, and recreational therapy during the 24-hour period. This is a documentation issue, as the staff interviewed were able to describe behaviour management strategies that reflect best practice, including the identification of triggers to reduce the occurrence of challenging behaviours. The family member interviewed reported that they have seen improvements in the behaviour management and reduced instances of challenging behaviours over the past 12 months.</p>	<p>two files reviewed of residents living in the dementia unit did not have care plans for behaviour management that meet contractual requirements.</p>	<p>residents living in the dementia unit have evidenced prevention-based strategies for minimising episodes of challenging behaviours; a description of how the behaviour of the resident is best managed over a 24-hour period or a description of the activities that meet the resident's needs in relation to individual diversional, motivational, and recreational therapy during the 24-hour period.</p> <p>60 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.