

# The Rest Homes Limited

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## Introduction

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

The audit has been conducted by HealthShare 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:

<b>Legal entity:</b>	The Rest Homes Limited
<b>Premises audited:</b>	Makoha Rest Home
<b>Services audited:</b>	Residential disability services - Intellectual; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical; Residential disability services – Sensory
<b>Dates of audit:</b>	Start date: 22 June 2017    End date: 23 June 2017
<b>Proposed changes to current services (if any):</b>	None.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	25



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Makoha Rest Home provides rest home and hospital level care for up to 34 residents. This second unannounced surveillance audit was conducted against the Health and Disability Service Standards and aspects of the service contract with the district health board (DHB).

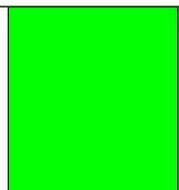
The audit process included the review of relevant policies and procedures; review of resident and staff files; observations and interviews with residents, family, management, staff, medical officers and another health professional.

Most requirements identified at the previous audit have been met. These include improvements in relation to human resource management (to employment agreements and criminal vetting); assessment and care planning (review of assessments, completion of initial assessments, signing of consent forms, initial medical assessments completed in a timely manner and copies of district nursing plans now in resident records); the management of residents with pressure injuries; medicines management (including review of medications by a medical officer, documentation and competency of staff); cleaning of the kitchen and monitoring of fridge and freezer temperatures and the calibration of medical equipment and hoists.

Requirements are still required to performance appraisals; review of care plans including updating of care plans as changes occur; ongoing development of the activities programme.

A further improvement identified at this audit is required to document evidence of discussion of elements of the quality programme.

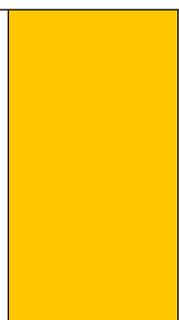
## Consumer rights

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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Residents are provided with information they need on entry to the service and this is regularly updated. Interviews with residents demonstrated they are provided with adequate information and that communication is open.

Resident meetings provide feedback and confirm regular communication and involvement. Communication records are maintained. If required, the service will access interpreters from the District Health Board. Residents are informed of the complaints process and there are policies and procedures in place to investigate complaints. The complaints register is current.

## 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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The facility manager provides administrative support, support for residents to access the community and management of payroll and contracts. The clinical nurse manager provides clinical oversight of service delivery. Both the facility and clinical managers

provide overall management of the service. A registered nurse is on each shift with health care assistants able to provide adequate support for residents.

There is a documented quality and risk and management system which includes a range of policies, procedures and associated forms. There is a system in place for recording adverse events and there is some documentation of discussion of quality data and trends.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Service provision is coordinated to promote continuity of service delivery. The residents and family interviewed confirm their input into care planning and access to a range of life experiences and choices. A sample of resident clinical files confirmed service delivery meets residents' needs.

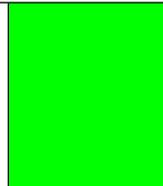
There is a planned activities programme with residents also accessing community activities.

The medicine management system is described in policy and implemented as per policy. Medication is securely stored.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. Residents' dietary needs are identified on admission and reviewed on a regular basis. Residents confirm that adequate fluids and food is provided and snacks are available between meals.

## 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.

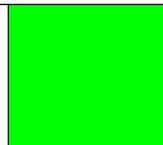


Standards applicable to this service fully attained.

All building and plant comply with legislation with a current building warrant of fitness in place. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Outdoor areas are available and accessible to residents.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

Restraint policies and procedures include definitions of restraint and enablers which are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection prevention and control policies include guidelines on prevention and minimisation of infection and cross infection. There is a documented surveillance programme with a low number of infections documented in the past year.

## 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	12	0	1	3	0	0
Criteria	0	36	0	1	4	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service operates a consumer complaints process that references Right 10 of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code). The service has an up-to-date complaint register which identifies the date of the complaint, the complainant, description of the issue and the actions taken.</p> <p>Consumer complaints received since the previous audit were sampled. A review of two complaints indicate that these are signed off with timeframes met for response and resolution as per policy. The clinical nurse manager confirms that there have been no complaints made to external authorities.</p> <p>Residents and family interviewed confirmed they have had the complaints procedure explained to them and they understood and know how to make a complaint if required. Staff were aware of their responsibility to record and report any consumer complaints they may receive.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	<p>FA</p>	<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 provided. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in accident/incident forms reviewed.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Family contact is recorded in residents' records on the newly implemented family communications record. The files sampled document that each family has been rung over the past six months to update family around progress and to gain input into care planning. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to participate in the entry process for their family member and in ongoing care options.</p> <p>Interpreting services are available from the DHB. There is one resident who is not able to speak English. There are some cards available for the resident and staff to prompt discussion and staff on site can interpret along with family. The information pack is available in large print and this can be read to residents.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All admission agreements sampled were signed on the day of admission.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Makoha Rest Home and Hospital provides rest home and hospital level care for up to 34 residents. On the days of audit there were 25 residents including the following: five under the long term chronic health conditions for under 65 years (two requiring rest home level care and three requiring hospital level care); two residents who are young people with disabilities including one resident who is using respite services; four residents funded by ACC including two requiring hospital level care, one requiring rest home level care and one who requires respite care who is also identified as a young person with disability. In total, there are 17 residents requiring rest home level care; six residents requiring hospital level and one using respite services.</p> <p>There is a business risk assessment and management plan in place which includes the quality plan. It contains the purpose, values, scope, and direction. The goals of the organisation are identified and the plan includes objectives and who is responsible. The plan has been briefly reviewed by the clinical nurse manager with further review in progress.</p> <p>The clinical nurse manager was appointed to the role in September 2016. The clinical manager is a registered nurse and has had four years' experience as a clinical manager in a previous organisation. They have had over ten years' experience working in aged care services and experience in working in ACC. They are supported by a facility manager who has been in the role since September 2015. The facilities manager provides support with administration; oversight of contracts and registration of residents. The clinical nurse manager reports to the owner who is a psychiatrist. The clinical nurse manager maintains their eight hours professional development per annum.</p>
<p>Standard 1.2.3: Quality And Risk Management</p>	<p>PA Low</p>	<p>The business operates a quality risk and management system which includes a range of policies, procedures and associated forms. The quality and risk management system includes resident satisfaction with clinical care and</p>

<p><b>Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>environmental systems and processes, internal audit, human resource management, adverse event management, health and safety, restraint minimisation practices and infection prevention and control systems.</p> <p>There are policies and procedures in place that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals by an external consultant. The policies include reference to interRAI assessments and care planning and the Health and Safety at Work Act. There is a document control system to manage the policies and procedures. This system ensures documents are approved, up to date, available to staff and managed to preclude the use of obsolete documents. Only the current versions of policies and procedures are accessible by staff.</p> <p>Key components of service delivery are linked to the quality management system. The quality and risk management system is linked with the health and safety, complaints management and infection prevention and control programme for the service through the internal auditing process. The internal audit system reviews practices and the key components of service delivery.</p> <p>Data is collated and analysed and the intention is to discuss these at the registered nurse meetings currently occurring at three monthly intervals and the staff meetings two monthly. The management meeting is held monthly and this includes attendance by the owner, clinical nurse manager and facility manager. This meeting has a set agenda which includes quality and risk management.</p> <p>Corrective action plans are developed from identified areas of improvement through the internal audits, hazards, incident forms, satisfaction surveys and the complaints management process and the management meeting. Corrective actions are documented and the corrective actions are signed off as completed.</p> <p>Actual and potential risks were identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those commonly associated with providing services. The risk and hazard register sighted included the identified risks, how these are monitored, if the risk is a significant risk and if the implemented actions can isolate, eliminate or minimise the risk. The hazard register is maintained for each area of the service.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	<p>FA</p>	<p>The service has clearly documented and known processes for reporting, recording, investigating and reviewing adverse events. A review of incident/accident records and analysis confirms that all events are reported, recorded and reviewed by the clinical nurse manager, as soon as possible. The staff are aware of the need to complete vital signs if there is an unwitnessed fall or head injury. A monthly record is retained of all incidents with these discussed at the staff meetings.</p> <p>The clinical nurse manager understands the responsibilities for essential notification to the relevant authorities. The service has had not had to report any adverse events to external agencies. The previous corrective action around reporting of pressure injuries has been addressed.</p>

family/whānau of choice in an open manner.		
<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>	PA Moderate	<p>Human resources policies describe good employment practices that meet the requirements of legislation. A sample of employee records confirmed that each employee has an employment agreement in place signed by the employer and the employee; an application form; evidence of criminal vetting for staff who have been employed in the last two years; letter of offer and a curriculum vitae. A copy of completed orientation and other external training is kept on file. Performance appraisals remain as an area for improvement.</p> <p>Professional qualifications are validated by the clinical nurse manager, including evidence of registration and scope of practice for registered health practitioners. This includes annual practicing certificates for the pharmacist; general practitioner and the physiotherapist. New staff receive an orientation/induction programme that covers the essential components of the service provided. There are five registered nurses who are trained in interRAI. A review of attendance records retained align with the annual training plan and confirm that the training provided meets requirements of the District Health Board contract.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There are documented and implemented processes that determine staffing levels and skill mix in order to provide safe service delivery. Staffing considers the layout of the service. The clinical nurse manager is onsite five days a week, Monday to Friday. There is at least one registered nurse on duty at all times and one or more caregivers on duty. Staffing is adjusted to meet resident needs with a caregiver initially providing a short shift in the morning now providing a longer shift for some days a week to cater for residents requiring additional cares. The clinical nurse manager is on call at all times and there is a registered nurse on 'night call' to answer any questions with these escalated if need be. One registered nurse for example phoned the Hospice in the weekend to query some cares for one resident. The care staffing levels for the service meet the requirements as specified in the District Health Board agreement.</p> <p>Additional staff include the cleaner; cooks and maintenance completed by the facility manager. A physiotherapist is employed for two or more hours a week. There is a diversional therapist and assistant contracted to support the service. The health care assistant's complete laundry duties with these described as per policy by staff interviewed.</p> <p>A review of the rosters for the past three months confirmed that staff are replaced when absent. There is also a staff member on each duty with a first aid certificate.</p> <p>The residents and the relative interviewed reported satisfaction with the skills of the staff and the care provided.</p>
Standard 1.3.12:	FA	Medication is stored securely with medicines stored in original dispensed packs. Weekly checks and six monthly

<p><b>Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>physical stock takes occur.</p> <p>The registered nurse was observed to give medication to residents and to sign at the time the medication is administered. The administration sheet is signed by two staff when a controlled drug is administered. Drop/sprays such as eye drops or nasal sprays are dated when opened. The temperature of the refrigerator used to keep medicines in is monitored daily and in the recommended range. The corrective actions identified at the previous audit related to these issues have been addressed.</p> <p>Current medication competencies for staff who administer medicines are current and now completed annually. This includes medication competencies for health care assistants who countersign for administration of medications. Administration records are maintained, as are specimen signatures.</p> <p>Medication audits have been conducted and corrective actions are implemented following the audits. There are currently no residents self-administering medicines currently however a medication file for a resident who was self administering medications in the past confirmed that a competency was signed and instructions were in place with checks completed daily. A resident can store their medicines in their room and all rooms are locked when the resident is not in the room. The corrective action identified at the previous audit has been addressed.</p> <p>The pharmacist completes a review of medication six monthly. Stocktakes are completed weekly for controlled drugs. Controlled medication is stored and administered as per policy.</p> <p>The medication files reviewed indicate that the general practitioner reviews the medications as directed and at least three monthly. The corrective action identified at the previous audit has been addressed.</p> <p>As required medication is prescribed correctly with indications for use documented and maximum dose documented.</p> <p>The medication policy, system and procedures comply with the aged care residential medication guidelines and current legislation.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></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>Kitchen staff have completed food safety training and cook all meals. The cook is aware of the residents' individual dietary needs and nutritional profiles are kept in the kitchen. These are updated on a six-monthly basis or as changes occur and the cooks put any changes on the white board as residents identify food they dislike.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided.</p> <p>The kitchen environment is clean, well-lit and uncluttered. The corrective action identified around cleanliness of the kitchen has been addressed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures with these within normal range.</p>

		<p>There is a seasonal menu, last reviewed by a dietitian in August 2015. Review of residents' files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals along with alternative nutrition appropriate to the residents are available. The clinical nurse manager and dietician are currently reviewing the menu.</p> <p>There is enough stock to last in an emergency situation for three days for all residents.</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. Interventions are documented for each goal in the long-term care plans. Interventions are documented when specific needs are identified, for example, around pain management.</p> <p>One of the two general practitioners interviewed confirmed that clinical interventions are effective and appropriate. Interventions from allied health providers are included in the long-term care plan as per individual need. This includes support from a podiatrist and assessment service coordinators. A psychologist providing support to one resident stated that the staff were working to address challenging behavioural needs for one resident and a safety and behavioural management plan with interventions described is documented. The plan is updated as changes occur. Behavioural management plans are documented with strategies to manage individual behaviours for other residents.</p> <p>Records of wound management for residents with pressure injuries and for two residents with a wound were sampled. All pressure injuries are dressed by the district nurses and the service now receives a copy of the plans. The corrective action identified at the previous audit has been addressed. Each resident with skin tears or a wound has a record of the assessment; diagram of position of the wound; plan and documentation of progress of healing at each change of dressing.</p> <p>Care staff document progress notes and observation charts are maintained. Staff confirmed they are familiar with the current interventions of the resident they are allocated.</p> <p>Short-term care plans are used to document short term episodes that arise for residents. These include short term cares for infections, wounds and other short term problems. Evidence of resolution of the issue is documented.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer,</p>	PA Moderate	<p>The service contracts a diversional therapist (DT) for four hours a week and they bring an activities assistant to support activities. They are on site two times a week. There is a volunteer who works for six hours. The facility manager takes residents to appointments, outings and shopping during the week. T</p> <p>he activities programme is available to all residents in the rest home and the hospital with some activities provided to young people under the age of 65 years. In the past, there have been lifestyle plans documented for</p>

<p>activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>each resident under the age of 65 years however these have not been reviewed in a timely manner. The care staff state that they also provide activities when they can and that there are some activities for young people.</p> <p>The group programme is documented on a monthly basis and displayed in the dining area. The activities programme includes a range of activities such as outings and cognitive activities and supports celebrations for residents. The service is required to review the activities programme to ensure that it includes a sufficient range of activities for young people under the age of 65 years and for those who do not wish to engage in the group programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Timeframes in relation to care planning evaluations are documented. In interviews, residents and family confirmed their participation in care plan evaluations.</p> <p>The residents' progress records are entered on each shift with the registered nurse documenting at least within 24 hours for residents requiring rest home level care and at each shift for those requiring hospital level care. When resident's progress is different than expected, the registered nurse contacts the general practitioners as required with both general practitioners confirming that staff notify them as soon as changes in a resident's condition has occurred.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p> <p>There is a requirement to ensure that six-monthly evaluation and review of the care plan occurs as scheduled.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building warrant of fitness expires 24 May 2018. There has been no reconfiguration of the building since the previous audit. There have been no changes to the fire evacuation plan and fire drills are conducted six monthly as required.</p> <p>All rooms are of sufficient size to accommodate residents and their activities. Equipment has been tested and tagged within the last year and all medical equipment has been calibrated within the last year. The corrective action identified at the previous audit around calibration of equipment has been addressed.</p> <p>The service has a planned and reactionary maintenance programme and the clinical nurse manager and facility manager have completed some refurbishment and changes in flooring covers since the last audit.</p> <p>There are indoor and outdoor areas that enable residents to complete activities and to safely access and navigate through the building.</p>

<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is aligned with the organisation's policies. Infections are recorded as quality indicators in the policy. Residents with infections have short term care plans completed to ensure effective management and monitoring of infections. Data around infections and discussion is expected to be reported at monthly staff and registered nurse meetings.</p> <p>A registered nurse is delegated as being the infection control nurse. The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events. Infection summary logs are maintained for infection events in individual resident's files reviewed. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the registered nurses, verbal handovers and progress notes. This was confirmed also through observation of a handover.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. Enabler use is documented in resident care plans as confirmed for one resident. The service has no restraints in use on the day of audit and has two residents using a lap belt and or chest belt as an enabler. All residents using an enabler are able to give consent for use. The clinical nurse manager confirms that there is no restraint used in the facility.</p>

## 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	Currently there are staff, registered nurse and management meetings. Currently the meetings are held two monthly; three monthly and monthly respectively. There is variable documentation of discussion around results, clinical components of service delivery and actions to take to address issues. The clinical nurse manager has had variable success with attendance at planned staff meetings and is intending to increase frequency of meetings. The registered nurses and clinical nurse manager confirm that there are daily meetings to discuss progress of residents and to identify any needs. Health care assistants state that they can discuss clinical issues daily with the registered nurse on duty and the clinical nurse manager. The handover process also allows for discussion of clinical issues.	There is a lack of documented discussion of quality improvement that occurs as a result of discussion of data tabled.	Document evidence of discussion of quality improvement.  90 days
Criterion 1.2.7.5 A system to identify, plan,	PA Moderate	There is a system to ensure staff receive education with training needs identified through the performance appraisal system. A review of a staff records indicates that performance appraisals are still required to be completed annually. On the	Performance appraisals are not completed	Ensure that staff have a performance

<p>facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>day of audit, three of the six staff files reviewed did not including a current performance appraisal. Two others were not required to have a performance appraisal having not been in the service for a year. This remains as a corrective action following the last audit with the risk rating raised to a moderate.</p>	<p>annually as per policy.</p>	<p>appraisal at least annually as per policy.</p> <p>60 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 Moderate</p>	<p>The diversional therapist works four hours a week. Some activities are planned and provided/facilitated to develop and maintain strengths including activities for residents under the age of 65 years. Some younger residents attend day programmes in the community. The group programme does not include a range of activities for young people or reference to one to one activities for those who do not wish to engage in group programmes. The corrective actions identified at the previous audit remain. The risk rating has remained as a moderate however the timeframe to address this has decreased to 60 days.</p>	<p>Activities are not sufficiently reviewed for residents under the age of 65 years or for one to one activities for those who cannot or chose not to engage in group activities.</p>	<p>Review the schedule/plan of activities for residents under the age of 65 years and/or one to one activities for those who cannot or chose not to engage in group activities.</p> <p>60 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	<p>PA Moderate</p>	<p>Evaluations are expected to be completed every six months. The registered nurses are able to describe updating of care plans and have been working to ensure the evaluation and subsequent updating of the care plan is completed in a timely manner. The general practitioner states that the staff respond to changes in care.</p> <p>Not all evaluation of care and care plans are reviewed six monthly as scheduled however the service has made progress at addressing the requirement raised at the previous audit around evaluation and review of care plans.</p> <p>InterRAI assessments are now completed for each resident and these are used to inform evaluation and review of care plan when these are documented. The corrective actions identified at the previous audit has been addressed.</p>	<p>Two of the files reviewed do not include a six-monthly evaluation and review of the care plan.</p>	<p>Ensure that an evaluation and updating of the care plan is completed six monthly.</p> <p>90 days</p>

<p>Criterion 1.3.8.3</p> <p>Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA</p> <p>Moderate</p>	<p>The registered nurses can describe updating of care plans as changes occur.</p> <p>The general practitioner states that the staff respond to changes in care.</p> <p>Not all care plans are updated as changes occur. The corrective action identified at the previous audit remains.</p>	<p>Not all care plans have been updated in response to changes in care.</p>	<p>Ensure that care plans are updated as changes are identified.</p> <p>90 days</p>

## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.