

# Northbridge Lifecare Trust

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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 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:

<b>Legal entity:</b>	Northbridge Lifecare Trust
<b>Premises audited:</b>	Northbridge Lifecare Trust Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 19 January 2015      End date: 19 January 2015
<b>Proposed changes to current services (if any):</b>	The use of 10 beds for either rest home or hospital (dual purpose beds) which have been approved for use by the Ministry of Health.
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	91

# 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
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

Northbridge Lifecare Trust Rest Home & Hospital continues to offer rest home and hospital level care for up to 96 residents. This includes 10 beds that can be used for either rest home or hospital level care. On the day of audit there were 40 hospital and 51 rest home beds occupied. The facility operates as a charitable trust with a board of trustees who oversee the governance of the service. The day to day services are managed by a director who works closely with the manager. The manager is supported by a clinical manager who is a registered nurse. There is a village which operates on the same site and this is not included in this audit.

The one area identified for improvement in the previous audit has been fully addressed. One new area identified as requiring improvement at this audit relates to human resource management processes. The requirements of the provider's agreement with the district health board were met.

## 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.	Green	Standards applicable to this service fully attained.
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Staff communicated effectively with residents and provide an environment conducive to effective communication. The service promoted open and honest communication with residents, and where appropriate, family/whanau.

Complaints management was undertaken to meet policy requirements. The service has a documented complaints management system which was implemented. There were no outstanding complaints at the time of audit.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The organisation's values, goals and mission statement have been identified in the business plan which is reviewed annually at board level. This document identified how services were planned and coordinated to meet residents' needs.

The quality and risk plan showed the measures taken to deliver services in a safe and effective manner. The service implemented corrective action planning to manage any areas of concern or deficits found. Quality management reviews included internal audit process, complaints management, incident/accident, risk and infection control data collection. Quality and risk management activities and results were shared among all staff and with residents, as appropriate.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identified that not all staff appraisals are up to date. Signed, completed staff orientation records could be located on the day of audit.

## 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.		Standards applicable to this service fully attained.
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The provision of all stages of care was conducted by staff who were appropriately trained and qualified. The assessment, provision of care, review and evaluation of care was provided within timeframes to safely meet the needs of the residents. There was evidence that the services are coordinated in a manner that promoted a team approach and continuity in care. The care plans document care provision that was consistent with the residents' assessed needs and desired outcomes. Care was evaluated at least six monthly to enable regular monitoring of the resident's progress towards achieving their desired outcomes. When progress was different to that expected, the service responded by initiating changes to the care plan.

Activities were planned and provided to facilitate and maintain the strengths and interests of the residents.

Food and fluids were provided to meet the needs of the residents. The nutritional services take into account the special needs, likes and dislikes of the residents.

A safe medication management system was observed and implemented. There were previous areas requiring improvement to ensure all medicines given are signed for and to ensure the three monthly medicine reviews were recorded on the medicine chart. These areas are now addressed and evidence improvements implemented since the last audit.

## 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. The service has had the use of 10 rest home level care beds approved for use as hospital level care as required (dual purpose beds). The service has appropriate equipment to manage this process safely. There has been no change in the facility footprint so no new emergency planning was required.

## 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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Policy identifies that enablers shall be voluntary and the least restrictive option to meet the needs of the resident to promote independence and safety. On the day of audit the restraint register showed that there were 13 enablers in use and no restraints in use. Staff undertake appropriate restraint minimisation education and could verbalise their knowledge and understanding of safe restraint management processes.

## 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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There is monthly surveillance of infections recorded for the rest home and hospital sections of the service. The infection data was recorded, analysed and reported to staff and management. Where trends were identified the staff implemented actions to reduce infections.

## 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)
<b>Standards</b>	0	16	0	1	0	0	0
<b>Criteria</b>	0	41	0	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	FA	<p>Complaints management was implemented to meet the sighted policy requirements. As confirmed during staff and family/whānau interviews, complaints management was explained during the admission process. Interviews confirmed that the open door policy operated by management made it easy to discuss concerns at any time. All complaints were documented and followed up by the manager and/or the clinical manager as shown in the complaints register sighted.</p> <p>Staff confirmed during interview that they understood and implemented the complaints process for written and verbal complaints that occur. The manager used the information to improve services as appropriate. This process was identified in the corrective actions follow up documented. There were no outstanding complaints at the time of audit. The complaints sighted since the previous audit were of a minor nature.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to</p>	FA	<p>The family/whanau confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented in the family communication sheets, on the accident/incident form</p>



<p>effective communication.</p>		<p>and in the residents' progress notes.</p> <p>The service promotes an environment that optimises communication and staff have received education related to appropriate communication methods. The service has not required access to interpreting services for the residents to date. Policies and procedures were in place if the interpreter services are needed to be accessed.</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>The five year business plan, which is reviewed at least annually by the board of directors, clearly identified a planned and coordinated approach to ensuring services offered are meeting the needs of residents. One director works within the facility and is responsible for the oversight of all services offered. He reports to the board at least monthly on all operational matters, including a presentation of clinical data statistics. More frequent reporting will occur on any serious issues that may arise. There is also a medical review committee which advises the board on clinical matter.</p> <p>The working director is supported by the Lifecare manager who has been working within age care for over 30 years, (15 of which have been in the senior management position for Lifecare Northbridge), and the clinical manager who is a registered nurse. Both the Lifecare manager and the clinical manager work within the care facility (rest home and hospital). All members of the management team had job descriptions which identified their experience, education, authority, accountability and responsibility for the provision of services.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a documented quality and risk management plan which identified risks and showed the strategies in place to manage risks. All potential and actual risks were reported at board level and reviewed regularly. Clinical risks were discussed monthly at staff meetings as confirmed in meeting minutes sighted and confirmed by staff during interview. The continuous quality improvement (CQI) committee had oversight for the management of clinical risk as shown in documents sighted.</p> <p>The service also operates a daily management report for clinical areas which was discussed as part of the daily staff handover so all staff were made aware of any</p>

		<p>newly identified risk.</p> <p>Quality data collection and analysis is maintained by the service and evaluation of results shared with staff and management. Quality improvements were put in place where indicated. One example related to the introduction of an additional staff member to assist across all areas to better manage workloads and to decrease the use of casual staff. Staff confirmed during interview that the process had worked well and management reported that the use of casual staff has reduced.</p> <p>All policies and procedures sighted were up to date, reflected current good practice and met legislative requirements. The document control system ensured that obsolete documents were removed from use.</p> <p>Regular audits are undertaken and corrective action planning is put in place to manage any deficits found. Staff confirmed that all follow up actions were discussed during handover and at regular staff meetings. Data was collected, trended, reviewed and evaluated for all key components of service (complaints, incidents and accidents, health and safety, hazards, restraint and infection control). Occupational safety and health practices were described in policy implemented and included staff training and education.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns they have are addressed by management.</p> <p>There was an up to date hazard register and the process for reporting hazards was understood by staff interviewed.</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>Incident reporting as described in policy was implemented by the service. This included the provider's statutory obligation related to essential notification reporting. Members of the management team verbalised their understanding of this reporting process.</p> <p>All adverse, unplanned or untoward events were recorded, reported and analysed. Information was used as an opportunity to improve services where indicated. For example there was specific documentation related to the reduction of resident skin tears. Staff meeting minutes identified that there has been a slight improvement in the monthly total of recorded skin tears. This is an ongoing project for the facility.</p> <p>If the service had any concerns related to a resident this information was shared in an open and honest manner with family/whānau as appropriate to ensure open</p>

		disclosure was maintained. This was confirmed during four family/whānau (two rest home and two hospital level care relative) interviews. All resident incidents are discussed at the six monthly family/whānau meetings as shown in documentation sighted in seven residents' files reviewed.
<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 Low	<p>Staff that required professional qualifications have them validated as part of the employment process and ongoing annually as confirmed in documentation sighted for ten RNs, three ENs, two GPs, one physiotherapist, the pharmacy and nine pharmacists. Caregivers had either completed all or part of recognised aged care qualifications, including dementia care (the 'ACE' programme).</p> <p>Policies and procedures implemented identified that most good employment practices were met. This was confirmed in the eight staff files reviewed with two issues being identified. One was that the current practice was for staff to take their completed sighted orientation records home and it was noted on computer that it had been completed. This was discussed with the Lifecare manager and from the time of audit a copy of the completed orientation records will be kept on site. Policy stated that staff annual appraisals will be undertaken but documentation identified these are not up to date.</p> <p>Signed job descriptions and employment contacts were sighted in all eight staff files reviewed. Staff ongoing education covered all areas of service provision and was clearly documented under each staff member's name. The annual in-service education calendar and off-site education undertaken by staff was related to the roles they undertake. All RNs and most caregivers held current first aid certificates.</p> <p>Interviews with six residents and four family/whānau members identified that residents' needs were met by the service. No negative comments were voiced on the day of audit.</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>The organisation has a clearly documented process to determine staffing requirements which was implemented. This was confirmed by a review of staffing rosters and the daily management report sheets sighted. Staff are replaced for sick leave and annual leave. Additional staff are rostered as required when the number of hospital level care residents increase if swing beds are used. There was a permanent staff member rostered to 'float' between areas and assist as staff required. All shifts were covered by a RN.</p> <p>Staff confirmed during interview that they had enough time on all shifts to meet</p>

		<p>residents' needs. Dedicated staff undertake cleaning, laundry and allied health duties. Kitchen services are contracted.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The previous audit identified actions required to meet the standards and the contract with the DHB at criterion 1.3.12.6 which were to ensure the medicines administration sheets is fully completed and to ensure that the three monthly reviews of medicines is recorded on the medicine chart. These have been improvements implemented and embedded in practice; evidence reviewed shows these issues are now addressed.</p> <p>Most of the medicines are supplied by the pharmacy in a pre-packed administration system. The medicines that are not pre-packed, such as liquid medicines, were individually supplied for each resident in the rest home, with some bulk supplies available in the hospital section. The medicines and pre-packed medicine sheets were checked for accuracy by the RN when they were delivered. The pre-packed medicines and the signing sheets were compared against the medicine prescription. The GP conducted medicine reconciliation on admission to the service and when the resident had any changes made by other specialists. Safe medicine administration was observed at the time of audit (RN administering the lunch time medicines in the rest home and an EN administering medicines in the hospital).</p> <p>The medicines and medicine trolley are securely stored in both the rest home and hospital sections of the service. The temperature of the medicine fridge was monitored weekly. The controlled drugs were stored in a safe. The controlled drugs were signed out by two staff at each administration and a weekly stock count was recorded in the controlled drug register. The additional six monthly controlled drug counts were recorded in the controlled drug register.</p> <p>All the medicine charts sighted had prescriptions that complied with legislation and aged care best practice guidelines. Each medicine was signed by the GP and had the required level of documentation to allow safe administration of the medicines. The prescriptions were legible, recorded the name, dose, route, strength and times for administration. The medicine charts recorded the regular, short course and 'as required' pro-re-nata (PRN) medicines for each resident. When medicines were discontinued, these were signed and dated by the GP. The medicine charts sighted had a current photo of the resident and recorded any medicine related allergies. Sample signature verification was recorded for all staff who administer medicines. All of the medicine charts were reviewed by the GP in the past three months.</p>

		<p>The standing orders comply with current legislation.</p> <p>Medication competencies were sighted for all staff that assist with medicine management; this included the RNs, ENs and some senior caregivers.</p> <p>The RN reported that there was one resident in the rest home who self-administers some of their medicines. The service's policies, procedures and self-administration guidelines were followed for this resident.</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 kitchen services are provided by an external contractor. The menu was reviewed by a dietitian as suitable for the older person living in long term care. The kitchen manager reported that when the menu was developed they received input from the residents, staff and management to develop a suitable menu. The service had a five week rotational menu with seasonal variations.</p> <p>Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets had these needs met. The kitchen service receives a copy of the residents' nutritional profile, with the residents' preference and special diets recorded and updated at least weekly. The residents and families reported satisfaction with the meals and fluids provided. The residents and families also commented on the 'atmosphere' and how 'well the staff served' the meals in the dining rooms.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines. The service has had an annual external audit from the contractor for food hygiene and health and safety requirements. There is an additional monthly internal audit and review of the kitchen services against the food safety guidelines. Fridge and freezer recordings were undertaken daily and met requirements. All foods sighted in the freezer were in their original packaging or labelled and dated if not in the original packaging.</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>	<p>FA</p>	<p>The provision of services and interventions were consistent with, and contributed to, meeting the residents' assessed needs and desired outcomes. The care plans reviewed were individualised and personalised to meet the assessed needs of the resident. The care was flexible and focused on promoting quality of life for the residents. All residents and family/whanau interviewed reported high satisfaction with the care and service delivery.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The residents are included in meaningful activities at the care facility and as part of the wider retirement village community. There are planned activities seven days a week, with volunteers assisting with activities on the weekends. Feedback was sought from residents at the residents meeting, during activities and informally at lunch time, when the activities staff assist with the serving of refreshments and interact socially with the residents. The occupational therapist reported that they gauge the responses of residents during activities and modified the programme related to residents' response and interests. The occupational therapist reported the activities were modified according to the capability and cognitive abilities of the resident, with examples given of how activities have been modified for residents with sight impairment. The activities programme covered physical, social, recreational and emotional needs of the residents. There was diversional therapy, activities, social and cultural assessments sighted in the residents' files reviewed. These were completed from information gained for the resident and their family. The occupational therapist used the assessments to develop an activities programme that was meaningful to the residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The evaluations of care were conducted at least six monthly on the resident review/resident evaluation form. The service conducts family/multidisciplinary reviews as part of the evaluation process. All the resident care evaluations sighted were resident-focused, indicated the degree of achievement or response to the support and/or interventions, and progress towards meeting the desired outcomes. Goals for the next six months were developed from the multi-disciplinary and resident/family meetings.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed.</p> <p>The residents and family/whanau interviewed reported high satisfaction with the care provided at the service.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are</p>	<p>FA</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires on 18 November 2015.</p>

<p>fit for their purpose.</p>		<p>Maintenance is undertaken by both internal maintenance and external contractors as required. Electrical safety testing occurred to meet legislative requirements. Clinical equipment, such as oxygen regulators, weigh scales (sit on and standing) and sphygmomanometers, were tested and calibrated at least annually or when required by an approved provider. The service had a purchase register which links into the maintenance schedule so that new equipment is included in the regular maintenance regime.</p> <p>The actual number of residents has not been increased, but 10 beds can be used for either rest home or hospital level care residents as approved by the Ministry of Health since the previous audit. Observation and staff interviews confirmed there was adequate and appropriate equipment to manage the additional requirements if all 10 swing beds are occupied at hospital level care.</p> <p>There had not been any change in the facility's footprint and all existing emergency planning process has been reviewed and remains unchanged.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring was in good condition, bathroom floors were non-slip, the correct use of mobility aids. There are specific storage areas to ensure work and resident areas are not cluttered. Regular environmental audits sighted identify that the service actively worked to maintain a safe environment for staff and residents. For example, one audit identified that hot water temperatures were above the required safe temperature and corrective actions taken were well documented.</p> <p>There are easily accessed outdoor areas for residents with adequate sun shades and seating. Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs and that it was maintained to a very high standard.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The status care level of the beds have been changed but there have been no changes to the building footprint. The emergency evacuation plan and general principles of evacuation were clearly documented and did not require any changes.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that</p>	<p>FA</p>	<p>The service conducts monthly surveillance for infections in the rest home and hospital. The service uses standardised definitions of infections that are appropriate to the long term care setting.</p>

<p>have been specified in the infection control programme.</p>		<p>The infection and surveillance data for November 2014 recorded an increase of urinary tract infections in the rest home. The analysis report showed that the increase is related to the change in season and hotter weather. There was an increase in encouraging residents with fluids and use of prescribed urinary alkalizers. The December 2014 records showed that one of the residents had recurrent urinary infections and additional informal staff education on hygiene was provided when assisting the resident with personal hygiene. The staff meeting minutes recorded this and the communication folder had a copy of the actions implemented to reduce the infections, which included further staff and resident education, increase in fluids, hand hygiene and informal education with the resident. The number of urine infections was reduced to one infection the following month.</p> <p>The surveillance data recorded an outbreak of nausea and vomiting in March 2014. The service conducted a review of how the service responded to the outbreak, including any concerns that the staff raised as a result. Analysis records that outbreak procedures were followed.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policy identified that the use of enablers was voluntary and the least restrictive option.</p> <p>There were 13 residents with enablers (bedside rails, chair lap belts and fall out chairs) identified. Enablers are used to assist residents to gain and/or maintain independence in movement and mobility whilst keeping them safe. All processes have been completed to meet policy requirements as confirmed in two file reviews undertaken for enabler use only. There were no restraints in use at the time of audit.</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)
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	<p>The service provided orientation for new staff as confirmed during staff and management interviews. Orientation material sighted covers all aspects of service provision and was directly related to staff members' job descriptions. One staff member who was new to the service confirmed the orientation she undertook prepared her to deliver services in a safe manner to residents.</p> <p>The service had a system in place to identify when each staff member's annual appraisal are due. Overdue appraisals were identified.</p>	<p>When staff files were reviewed no completed documented evidence could be located related to staff orientation as staff are given the completed records to take home. There was a computer entry to say the orientation process was completed but it does not show exactly what each person completed.</p> <p>Five of the eight staff files reviewed did not contain up to date appraisals with one appraisal being eight months overdue. Although the overdue appraisals are identified no follow-up had been undertaken to get them up to date.</p>	<p>Ensure there is auditable evidence related to the completion of staff orientation and that staff appraisals are undertaken annually to meet policy requirements.</p> <p>180 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.