

Oceania Care Company Limited - Duart Lifestyle Care

Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Oceania Care Company Limited

Premises audited: Duart Lifestyle Care

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 3 February 2015 End date: 4 February 2015

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: 61

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 |
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|  | 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 |
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| | 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

Duart Lifestyle Care (Oceania) can provide care for up to 66 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

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

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management team. Service delivery is monitored. Staffing levels are reviewed for anticipated workloads and acuity.

Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. | | Standards applicable to this service fully attained. |
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Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive.

Organisational management

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| 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. |
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Oceania has a documented quality and risk management system that supports the provision of clinical care and support at Duart Lifestyle Care. Policies are reviewed at head office and quality and risk performance is reported through meetings at the facility and are monitored by the organisation's management team through the business status reports.

Benchmarking reports are produced and include incidents/accidents, infections, complaints and clinical indicators. These are used to provide comparisons with other facilities.

There are human resource policies implemented around recruitment, selection, orientation and staff training and development.

Staff identified that staffing levels are adequate and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed. Staff are allocated to support residents as per their individual needs.

Continuum of service delivery

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| 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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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the person centred care plan is developed over the first three weeks. Care plans reviewed were individualised and risk assessments were completed. In the files reviewed residents' response to treatment was evaluated and documented and there was evidence that care plans were evaluated six monthly, with relatives notified regarding changes in a resident's health condition.

Activities are appropriate to the age, needs and culture of the residents and support their interests and strengths. The residents and families interviewed expressed being satisfied with the activities provided by the diversional therapist.

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

The facility utilises four weekly rotating summer and winter menus reviewed by a dietician. The facility uses the services of a cook and a chef.

Safe and appropriate environment

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| 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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All building and plant complied with legislation with a current building warrant of fitness is in place. A preventative and reactive maintenance programme is in place, which includes equipment and electrical checks. The environment is appropriate to the needs of the residents. Fixtures, fittings, floor and wall surfaces are made of accepted materials for this environment.

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

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

Restraint minimisation and safe practice

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| 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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The facility actively minimises restraint use. The restraint minimisation programme defines the use of restraints and enablers. The restraint register was reviewed and was current at the time of the audit.

Policies and procedures comply with the standard for restraint minimisation and safe practice. Risk assessment, documentation, monitoring, maintaining care, and reviews were identified, recorded and implemented. Residents using restraints had no restraint-related injuries. Staff members receive adequate training regarding the management of challenging behaviour and restraint use.

Infection prevention and control

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

Standards applicable to this service fully attained.

The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control was conducted according to their education and training programme and recorded in staff files.

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. The surveillance data is collected monthly for benchmarking. Appropriate interventions are in place to address the infections. There are adequate sanitary gels and hand washing facilities for staff, visitors and residents. Staff members were able to explain how to break the chain of infection.

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) |
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| Standards | 0 | 50 | 0 | 0 | 0 | 0 | 0 |
| Criteria | 0 | 101 | 0 | 0 | 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) |
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| 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 |
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| <p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p> | FA | <p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. All staff had training in 2014.</p> <p>Interviews with the staff confirmed their understanding of the Code. Examples were provided by staff on ways the Code was implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</p> <p>The information pack provided to residents on entry includes how to make a complaint, a code of rights pamphlet and advocacy information.</p> <p>The auditors noted respectful attitudes towards residents on the day of the audit.</p> |
| <p>Standard 1.1.10: Informed Consent</p> | FA | <p>There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Staff ensure that all</p> |

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| <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p> | | <p>residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identified that informed consent was collected.</p> <p>Interviews with staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families/whānau during the admission process.</p> <p>The policy and procedure include guidelines for consent for resuscitation/advance directives. A review of files noted that all had appropriately signed advanced directives.</p> |
| <p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p> | <p>FA</p> | <p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Resident information around advocacy services was available at the entrance to the service at the time of the audit.</p> <p>Staff training on the role of advocacy services was included in training on The Code of Health and Disability Consumers' Rights – last provided for staff in 2014.</p> <p>Discussions with family and residents identified that the service provided opportunities for the family/EPOA to be involved in decisions and they stated that they have been informed about advocacy services.</p> <p>The resident files included information on residents family/whanau and chosen social networks with a communication sheet kept on the resident file and completed when family visit, ring etc.</p> |
| <p>Standard 1.1.12: Links With Family/Whānau And Other Community</p> | <p>FA</p> | <p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and</p> |

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| <p>Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p> | | <p>visitors can arrange to visit after the doors are locked.</p> <p>Families interviewed confirmed they could visit at any time and were always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friends networks.</p> |
| <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 organisation's complaints policy and procedures is in line with the Code and included periods for responding to a complaint. Complaint forms were available at the entrance at the time of the audit.</p> <p>The complaints register was reviewed and included: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint was held in the complaint's folder.</p> <p>Three complaints reviewed indicated that the complaints were investigated promptly with the issues resolved in a timely manner.</p> <p>Residents and family members interviewed stated that they would feel comfortable complaining.</p> <p>The business and care manager stated that there had been no complaints with the Health and Disability Commission since the previous audit or with other authorities.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p> | <p>FA</p> | <p>The business and care manager, clinical manager or a registered nurse discusses the Code, including the complaints process with residents and their family on admission.</p> <p>Discussions relating to the Code could also be held at the resident meeting.</p> <p>Residents and family interviews confirmed their rights were being upheld by the service.</p> <p>Information regarding the Health and Disability Advocacy Service was clearly displayed in the foyer of the facility.</p> |

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| | | <p>The resident right to access advocacy services was identified for residents and advocacy service leaflets were available at the entrance to the service. If necessary, staff could read and explain information to residents as stated by the health care assistants and registered nurses interviewed.</p> <p>Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private. Residents and family members were able to describe their rights and advocacy services particularly in relation to the complaints process.</p> |
| <p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p> | <p>FA</p> | <p>The service has a philosophy that promotes dignity, respect and quality of life.</p> <p>The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Resident support needs are assessed using a holistic approach. The initial and on-going assessment included gaining details of people's beliefs and values with care plans completed with the resident and family member (confirmed by residents and family interviewed).</p> <p>Interventions to support these are identified and evaluated.</p> <p>Residents were addressed by their preferred name and this was documented in files reviewed.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour.</p> <p>The service ensures that each resident had the right to privacy and dignity, which is recognised and respected. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which could be used for private meetings.</p> <p>Health care assistants interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas –</p> |

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| | | <p>observed on the days of the audit. Residents and families interviewed confirm the residents' privacy is respected.</p> <p>Health care assistants interviewed reported that they encourage the residents' independence by encouraging them to be as active as possible. A physiotherapist is available two days a week.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect. Staff when interviewed were aware of the signs of abuse and neglect.</p> <p>Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified.</p> <p>There are church services at least twice a week.</p> <p>There are clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.</p> |
| <p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p> | <p>FA</p> | <p>The service implements their Maori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.</p> <p>Links to local kaumatua and Maori services are through the district health board.</p> <p>There was one Maori resident living at the facility during the audit. There were staff that identified as Maori.</p> <p>Staff reported that specific cultural needs were identified in the residents' care plans and this was sighted in files reviewed.</p> <p>Staff interviewed stated that they were aware of the importance of whanau in the delivery of care for the Maori residents.</p> |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> | <p>FA</p> | <p>The service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their</p> |

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| <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p> | | <p>representative.</p> <p>There is a culture of choice with the resident determining when cares occur, times for meals, choices in meals and choices in activities for example. Health care assistants were able to give examples of how choice was given to residents who had non-verbal ways of communicating.</p> <p>Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident's cultural values and beliefs. This information is used to develop a care plan.</p> |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p> | <p>FA</p> | <p>The facility implements Oceania policies and processes to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training includes discussion of the staff code of conduct and prevention of inappropriate care.</p> <p>Job descriptions included responsibilities of the position, ethics, advocacy and legal issues with a job description sighted in staff files reviewed.</p> <p>The orientation and employee agreement provided to staff on induction includes standards of conduct with a code of conduct signed by staff when they join the organisation.</p> <p>Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the health care assistants' role and responsibilities.</p> |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p> | <p>FA</p> | <p>Duart Lifestyle Care implements Oceania policies to guide practice. These policies align with the health and disability services standards and are reviewed bi-annually. A quality framework supports an internal audit programme. Benchmarking occurs across all of the Oceania facilities.</p> <p>There is a training programme for all staff and managers are</p> |

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| | | <p>encouraged to complete management training. There is a monthly regional management meeting.</p> <p>Specialised training and related competencies are in place for the registered nursing staff.</p> <p>Residents and families interviewed expressed a high level of satisfaction with the care delivered.</p> <p>The general practitioner reported a high standard of care provided at the service.</p> <p>Consultation is available through the organisation's management team that includes registered nurses, regional manager, dietitian etc. A physiotherapist is available two days a week.</p> <p>The key projects implemented in the past year included the following: a) response to resident feedback around the van leading to the purchase of a new van; b) a reduction in the use of restraint in the last six months; c) development of a store cupboard into a physiotherapy room; d) review of the activities programme to include the appointment of a diversional therapist.</p> |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</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 available. Family were informed if the resident had an incident, accident, had a change in health or a change in needs, as evidenced in completed accident/incident forms. Family contact was recorded in the residents' files reviewed.</p> <p>Interviews with family members confirmed they were kept informed. Family also confirmed that they were invited to the care planning meetings for their family member and could attend the resident meetings.</p> <p>Interpreter services are available from the district health board. At the time of the audit there were no residents requiring interpreting services. Staff interviewed were able to describe interpreting body language and sounds for one resident who was non-verbal with the family identified as</p> |

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| | | <p>a key advocate for the resident.</p> <p>The information pack is available in large print and this can be read to residents.</p> <p>Training records evidenced staff received training around communication in 2014.</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. On review, all 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> | FA | <p>Duart Lifestyle Care is part of the Oceania Group with the executive management team including the chief executive, general manager, regional manager, operations manager and clinical and quality managers providing support to the service.</p> <p>Communication between the service and managers takes place on at least a monthly basis.</p> <p>Oceania has a clear mission, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training provided annually.</p> <p>The facility can provide care for up to 66 residents with 20 identified rest home beds and 46 hospital beds. During the audit there were 61 residents living at the facility including 28 residents requiring rest home level of care and 33 residents requiring hospital level of care.</p> <p>The business and care manager is responsible for the overall management of the facility and has over 20 years' experience as a registered nurse in diverse areas of inpatient services with five years' experience as a manager in aged care services. The business and care manager has completed at least eight hours training relevant to the role per year.</p> |
| <p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is</p> | FA | <p>In the absence of the business and care manager, the clinical manager is in charge with support from the regional manager and clinical and quality manager (organisational). The clinical manager had been</p> |

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| <p>managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p> | | <p>appointed into the role in 2008 and has over 10 years' experience in aged care nursing.</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>Duart Lifestyle Care uses the Oceania quality and risk management framework that is documented to guide practice. The operations and business brief reviewed identified specific areas for development and the plan was documented and reported on through the business and care manager's reports to the executive team.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies were noted to be readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to say that they have read and understand these.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, pressure injuries, soft tissue/wounds, and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. There was evidence noted of documentation that included collection, collation, and identification of trends and analysis of data.</p> <p>Meeting minutes evidenced communication with all staff around all aspects of quality improvement and risk management. There are also resident meetings that keep residents informed of any changes. Staff reported that they were kept informed of quality improvements.</p> <p>There is an annual family and resident satisfaction survey with a high level of satisfaction documented.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly.</p> |

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| <p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p> | <p>FA</p> | <p>The business and care manager is aware of situations in which the service needs to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There have been no times since the last audit when authorities have had to be notified.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Ten incident reports reviewed had a corresponding note in the progress notes to inform staff of the incident. There was evidence of open disclosure for each recorded event.</p> <p>Information gathered around incidents and accidents is analysed with evidence of improvements put in place.</p> |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p> | <p>FA</p> | <p>The registered nurses and the clinical manager hold current annual practising certificates along with other health practitioner's involved with the service.</p> <p>Staff files reviewed included appointment documentation (e.g. signed contracts, job descriptions, reference checks and interviews), with an appraisal process in place. First aid certificates were held in the staff files.</p> <p>All staff completed an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrated competency on a number of tasks including personal cares.</p> <p>Annual competencies are completed by care staff (e.g. hoist, oxygen use, hand washing, wound management, medication management, moving and handling, restraint, nebuliser, blood sugar and insulin,</p> |

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| | | <p>assisting residents to shower). The organisation has a mandatory education and training programme in place. Training records evidenced staff attendances, which were documented. Education and training hours was noted to be at least eight hours a year for each staff member.</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 staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy.</p> <p>There were 61 staff including 7 registered nurses, a diversional therapist and 34 health care assistants. There were two registered nurses on each morning and at least one on each shift.</p> <p>Residents and families interviewed confirmed staffing was adequate to meet the residents' needs.</p> |
| <p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p> | FA | <p>The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family. There was sufficient detail in resident files reviewed to identify residents' ongoing care history and activities.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff interviewed could describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information can be accessed in a timely manner.</p> <p>Files reviewed evidenced that entries were legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member including designation.</p> <p>Resident files were protected from unauthorised access by being locked away in an office.</p> <p>Information containing sensitive resident information was not displayed</p> |

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| | | in a way that could be viewed by other residents or members of the public. Individual resident files reviewed demonstrated service integration. This included medical care interventions. Medication charts are in a separate folder with medication. |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>Residents' entry into the service is facilitated in a competent, equitable, timely, and respectful manner. Pre-admission packs are provided for families and residents prior to admission. Admission agreements were signed for all residents files reviewed, and were kept securely in the administration office. The facility requires all residents to have Needs Assessment Service Coordinators (NASC) assessments prior to admission, to ensure they are able to meet the resident's needs.</p> <p>The registered nurses (RNs) admit new residents into the facility, which was confirmed during interview. Evidence of the completed admission records were sighted. The RNs receive hand-over from the transferring agency, for example the hospital and utilise this information in creating the appropriate person centred care plan (PCCP) for the resident.</p> |
| <p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p> | FA | <p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.</p> <p>The CM reported that they include copies of the resident's records; including GP visits; medication charts; current PCCPs; upcoming hospital appointments and other medical alerts when a resident is transferred to another health provider.</p> |
| <p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p> | FA | <p>Medicine management policies and procedures are implemented, and include processes for safe and appropriate prescribing, dispensing and administration of medicines. The area was observed to be free from heat, moisture and light, with medicines stored in original dispensed packs, in a locked medicines trolley. Medicine charts reviewed listed all medications the resident was taking, including name, dose, frequency</p> |

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| | | <p>and route to be given. Charts were signed by the GP. All entries were dated and allergies recorded. All charts had photo identification. Discontinued medicines were signed and three monthly GP reviews were evident in charts reviewed.</p> <p>All medicines are prescribed by the GPs using pharmacy generated medication administration charts. Medication reconciliation policies and procedures are implemented. Medication fridges are monitored regularly. Controlled drugs are kept inside a locked cupboard and the controlled drugs register was current and correct on review. Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy.</p> <p>Medication administration was observed. The staff member checked the identification of the residents, completed cross checks of the medicines against the prescription, administered the medicines and then signed off after the resident took the medicines.</p> <p>Education in medicine management is conducted. Staff are authorised to administer medications. This requires completion of medication competency testing, in theory and practice. All staff members responsible for medicines management complete annual competencies.</p> <p>Self-administration of medicine policies and procedures are in place and sighted. There were no residents who self-administered their own medication at the time of the audit.</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 residents' individual food, fluids and nutritional needs are met. Residents are provided with a well-balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked on-site. The summer menu was last reviewed by the dietitian in September 2014, while the winter menu is due for review in April 2015. The menu review is based on nutritional guidelines for the older people in long-term residential care. A dietary assessment is completed by the RNs or the CM on admission. This information is shared with kitchen staff to ensure all needs, food allergies, likes, dislikes and special diets are catered for. The facility provides modified diets (e.g. puree diets) to meet the dietary needs of the residents.</p> |

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| | | <p>The RNs or CM provide the cook or the chef with copies of dietary assessments. A white board in the kitchen also contains important reminders about modified diets as well as preferences of residents.</p> <p>The chef interview confirmed documentation of kitchen routines. Nutrition and safe food management policies define the requirements for all aspects of food safety. A kitchen cleaning schedule is in place and is implemented. Labels and dates on all containers and records of food temperature monitoring are maintained. The chiller, fridge and freezer temperatures are monitored. The chef and the kitchen assistant has current food handling certificates.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.</p> |
| <p>Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>There is an adequate documented process for the management of declines to entry into the facility. Records of enquiry are maintained and in the event of decline, information is given regarding alternative services and the reason for declining services.</p> <p>The clinical manager (CM) assesses the suitability of residents and used an enquiry form with appropriate questions regarding the specific needs and abilities of the resident. When residents are not suitable for placement at the service, the family and or the resident are referred to other facilities, depending on their level of needs.</p> |
| <p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p> | FA | <p>The resident's needs, support requirements, and preferences are collected and recorded within required timeframes. The RNs or the CM complete a variety of risk assessment tools on admission. Additional assessments were sighted in the resident's file including the medical assessment completed by the GP and recreational assessment completed by the diversional therapist.</p> <p>The files reviewed evidenced baseline recordings recorded for weight management and vital signs with monthly monitoring. Staff interviews confirmed that the families were involved in the assessment and review</p> |

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| | | processes. The outcomes of the assessments are used in creating an initial care plan, the PCCP and a recreational plan for each resident. |
| <p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p> | FA | <p>The PCCPs reviewed were resident focused, integrated, and promoted continuity of service delivery. An initial plan of care is developed on admission while the PCCPs are developed within three weeks of admission. The facility uses an integrated document system where the GP, allied services, the RNs, diversional therapist, physiotherapist and other visiting health providers write their care notes.</p> <p>The resident files reviewed had sections for the resident's profile, details, observations, PCCP, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best practice. Goals were realistic, achievable and clearly documented. The service recorded intervention for the achievement of the goals.</p> |
| <p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p> | FA | <p>Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. In files reviewed, interventions were documented for each goal in the PCCPs. Other considerations like pain management, dietary likes and dislikes, appropriate footwear, walking and hearing aids were included in the PCCPs.</p> <p>Interview with the GP confirmed clinical interventions were effective and appropriate. Review of files indicated that interventions documented by allied health providers were included in the PCCP and included; the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist.</p> <p>Residents and family involvement in the development of goals and review of care plans is encouraged. Multidisciplinary meetings are conducted by the CM to discuss and review PCCP's. All resident files reviewed during the on-site audit were signed by either the resident or by their families.</p> |

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| <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 activities programmes reviewed confirmed that independence is encouraged and choices are offered to residents. The diversional therapist (DT) coordinates the activity programmes. The DT provides different activities addressing the abilities and needs of residents in the hospital and rest home. Activities resource materials are accessible for the staff to utilise. Activities include physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. During the onsite visit, activities included residents going for an outing, music and one-on-one activities. Residents and family confirmed they were satisfied with the activities programme. Each resident has their own copy of the programme.</p> <p>On admission the DT completes a recreation assessment for each resident. The recreation assessments include personal interests, family history, work history and hobbies to ensure resident's participation in the activities. The DT provides the RNs with the recorded assessments to ensure it is included in the PCCPs. Resident files reviewed demonstrated that review of activity plans were completed every six months, as part of the multi-disciplinary review, or when the condition of the resident changed. All resident files reviewed during the onsite audit had current activity assessments in place.</p> <p>Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included outings as well as community involvement.</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 resident files reviewed showed PCCP's had six monthly reviews completed. Clinical reviews were documented in the multi-disciplinary review (MDR) records, which included input from the GP, RNs, HCAs, DT and other members of the allied health team. Daily progress notes were completed by the HCAs and RNs. Progress notes reflect daily responses to interventions and treatments. Changes to care are documented. Residents are assisted in working towards goals. Short term care plans are developed for acute problems for example: infections; wounds; falls and other short term conditions. Additional reviews include the three monthly medication reviews by the GP.</p> |

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| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p> | <p>FA</p> | <p>The CM stated that residents are supported in accessing or in referral to other health and disability providers. The RN's refer residents for further management to the GP; dietician; physiotherapist; speech language therapist and mental health services.</p> <p>The GP confirmed involvement in the referral processes. The service follows a formal referral process to ensure continuity of service delivery. The review of resident folders included evidence of recent external referrals to the physiotherapist and specialists.</p> |
| <p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p> | <p>FA</p> | <p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements are in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets were noted to be available throughout the facility and accessible for staff. The hazard register reviewed was current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>At the time of the audit, there was provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear; and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p> | <p>FA</p> | <p>A current building warrant of fitness is displayed – expiry date 26 June 2015. There have been no building modifications since the last audit.</p> <p>A planned maintenance schedule was implemented at the time of the audit. On the day of the audit the following equipment was available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. An annual test and tag programme is implemented and this was up to date with BV Medical checking and calibrating clinical equipment</p> |

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| | | <p>annually.</p> <p>Interviews with staff and observation of the facility confirmed there was adequate equipment.</p> <p>Quiet areas were observed throughout the facility for residents and visitors to meet and there were areas that provide privacy when required. During the audit, the deck and grass areas were well used with shade, seating and outdoor tables.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p> | FA | <p>There are adequate numbers of accessible toilets/bathing facilities located at each end of the wings and in the middle. Some rooms also have ensuite toilet facilities. Visitors, toilets and communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members interviewed reported that there were sufficient toilets and showers.</p> |
| <p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p> | FA | <p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for both the equipment (e.g. hoists, at least two staff and the resident).</p> <p>On the day of the audit it was observed that rooms were personalized with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own.</p> <p>There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required and a mobility scooter bay.</p> |

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| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate and accessible areas to meet their relaxation, activity, and dining needs.</p> | <p>FA</p> | <p>The service has lounge/dining areas including areas that can be used for activities and smaller lounge areas on each floor. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>Dining areas are located on each floor and residents can choose to have their meals in their room.</p> |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p> | <p>FA</p> | <p>At the time of the audit, laundry was subcontracted out. There is a dirty area in the laundry to place the laundry bags ready for collection and a separate clean area for clothes and linen to be returned. Staff are required only to return linen to the rooms. Residents and family members stated that the laundry was well managed and they get back their clothes.</p> <p>There are cleaners on site during the day, five days a week. The cleaners have a lockable cupboard to put chemicals in on the trolley and all were locked when out in the wings on the days of the audit. All chemicals were in appropriately labelled containers. Ecolab products were used at the time of the audit with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p> |
| <p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p> | <p>FA</p> | <p>An evacuation plan was approved by the New Zealand Fire Service on 18 January 2002. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with the last drill conducted in June and November 2014. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There is always one staff member at least with a first aid certificate on duty.</p> <p>All required fire equipment was sighted on the day of audit and all</p> |

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| | | <p>equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas BBQ's.</p> <p>An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways, dining room and hairdressing space. Call bell audits are routinely completed and residents and family stated that there were prompt responses to call bells.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening that confirms that security measures have been put in place. An external contractor also completes a night check.</p> |
| <p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p> | FA | <p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. At the time of the audit, there was a designated external smoking area.</p> <p>Family and residents interviewed confirmed the facilities were maintained at an appropriate temperature.</p> |
| <p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p> | FA | <p>The responsibility for infection control is clearly defined and there are clear lines of accountability for infection control matters in the facility. The service was in the process of changing from one infection control coordinator (IC) to another at the time of the audit. The infection control committee has representatives from the kitchen, cleaning services, laundry, HCA and the CM. Monthly meeting minutes were sighted. The CM reported that hand-washing audits were completed several times during the year.</p> <p>There is an infection control programme in place that was last reviewed at the end of February 2014. Infection control is part of the monthly staff</p> |

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| | | meeting agenda. When a resident presents with an infection, staff send specimens to the laboratory for sensitivity testing. The GP prescribes antibiotics as per sensitivity, which was confirmed during interview. The RN's create short term care plans and review the effectiveness of the prescribed antibiotics when the treatment is completed. The CM collates all the surveillance data for benchmarking. Infections are discussed during staff meetings, and meeting minutes were sighted. |
| <p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p> | FA | <p>There are adequate human, physical, and information resources to implement the infection control programme and to meet the needs of the organisation. Hand washing signs were sighted around the facility to remind staff and residents of the importance of proper hand washing.</p> <p>The facility maintains regular in-service trainings for infection control including standard precautions, personal protective equipment, cleaning, infectious diseases and hand washing. Training records were sighted that are aligned with the Oceania training planner.</p> |
| <p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> | FA | <p>Documented policies and procedures for the prevention and control of infection reflect accepted good practice and relevant legislative requirements and are readily available and implemented at the facility. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p> <p>The policies and procedures sighted complied with relevant legislation and current accepted good practice.</p> |
| <p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p> | FA | <p>The organisation provides relevant education on infection control to all service providers, support staff, and residents. The infection control education is provided by either the CM or by external resource speakers. The CM includes hand washing and standard precautions as additional infection control training. Residents interviewed were aware of the importance of hand washing.</p> |

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| <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>The clinical manager (CM) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered was clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that are specified in the infection control programme. Infection control processes are in place and documented.</p> <p>The infection control surveillance register includes monthly infection logs and antibiotics use. The organisation has an internal benchmarking system. Infections are investigated and appropriate plans of action were sighted in meeting minutes. The surveillance results are discussed in the staff meeting.</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 facility actively minimises the use of restraint. Restraints noted to be used in the facility included lap belts and bedrails. At the time of the audit, there were three residents using restraints and five using enablers. The files reviewed for restraint and enabler use showed enabler use was voluntary and the least restrictive option for the residents. Files reviewed demonstrated that residents who use restraints have risk management plans in place. The files reviewed showed that restraints were documented in their PCCP's. There were no restraint related injuries reported. Bedrails have specialised bedrail covers when in use, as part of the risk management plan.</p> <p>The service has a documented system in place for restraint use, including a current restraint register. Records included assessments, consents, monitoring and evaluation forms. Consent forms, authorisation and plans forms. Reasons for restraint use are considered and documented in the restraint assessments. The CM is the restraint coordinator.</p> |

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| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | <p>FA</p> | <p>The facility maintains a process for determining approval of all types of restraints used. The restraint coordinator completes a restraint assessment which is then discussed with the GP prior to commencement of any restraints. The restraint approval group is defined in the restraint minimisation and safety policies and procedures.</p> <p>In files reviewed the duration of each restraint was documented in the restraint plans of residents. Health care assistants are responsible for monitoring and completing restraint forms when the restraints are in use. Evidence of on-going education regarding restraint and challenging behaviour was evident in staff files. Staff members are made aware of the residents using restraints during monthly staff meetings. This was confirmed during staff interviews.</p> |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p> | <p>FA</p> | <p>Restraint assessments include: identification of restraint related risks; underlying causes for behaviour that require restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p> | <p>FA</p> | <p>Before resorting to the use of restraint, the restraint coordinator utilises other means to prevent the resident from incurring injury for example the use of low beds, mattresses and sensor mats. Restraint consents reviewed were signed by the GP, the resident (when applicable) family and the restraint coordinator and the restraint monitoring forms were completed by the HCAs.</p> <p>Files reviewed evidenced that restraints were incorporated in the PCCP's and reviewed three monthly. The service completed a project in where they actively reduced the use of restraint by looking at other means of managing falls, and risks to residents. There were previously eight residents using restraints where at the time of the on-site audit, the service had three residents using restraint. The restraint register was up to date and the facility uses restraint safely.</p> |

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| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p> | <p>FA</p> | <p>The restraint coordinator evaluates all episodes of restraint. PCCPs are evaluated six monthly. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required.</p> <p>The resident (if able) and the family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices are reviewed.</p> |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | <p>FA</p> | <p>The facility demonstrated the monitoring and quality review of their use of restraints. Their audit schedule was sighted and included restraint minimisation reviews. The content of the internal audits included the effectiveness of restraints, staff compliance, safety and cultural considerations. Staff knowledge and good practice is also included in their quality reviews. Staff monitor restraint-related adverse events while using restraint.</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.

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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.

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End of the report.