# Village at The Park Care Limited

## 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 Health and Disability Auditing New Zealand 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Village at The Park Care Limited

**Premises audited:** Village At The Park

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

**Dates of audit:** Start date: 16 February 2015 End date: 17 February 2015

**Proposed changes to current services (if any):** Three rooms are assessed as suitable for hospital level care.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 85

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

The Village at the Park Lifecare facility provides care for up to 92 residents across three service levels (hospital, rest home, dementia level care) with 85 residents living at the facility during the audit.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The general manager is appropriately qualified registered nurse and experienced and is supported by three care managers (registered nurses and enrolled nurse). There are quality systems and processes being implemented. The service has been actively working on reducing the incidence of falls and challenging behaviours, and reducing staff turnover. Feedback from residents and families was positive about the care and services provided. An induction and in-service training programme is in place to provide staff with appropriate knowledge and skills to deliver care.

There are two areas of continuous improvement awarded around good practice and reducing the use of restraints.

One area for improvement has been identified around an increase in dual call bell system for residents assessed as requiring sensor mats.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

Staff 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. They receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families.

Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents.

Evidence-based practice is evident, promoting and encouraging good practice and has been given a rating of continuous improvement. A policy on open disclosure is in place. There is evidence that residents and family are kept informed.

The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## Organisational management

|  |  |  |
| --- | --- | --- |
| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

Services are planned, coordinated, and are appropriate to the needs of the residents. A general manager and three care managers are responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A robust health and safety programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. A comprehensive orientation programme is in place for new staff. On-going education and training for staff is in place.

Registered nursing cover is provided 24 hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

The residents’ files are appropriate to the service type.

## 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. |

There is comprehensive service information available. Initial assessments and risk assessment tools are completed by the registered nurses on admission. Lifestyle plans and evaluations were completed by the registered nurses within the required timeframe. Lifestyle plans demonstrate service integration, were individualised and evaluated three monthly in the rest home and hospital and six monthly in the dementia unit. Lifestyle plans, written evaluations, assessment tools and monitoring forms are completed and updated on the on-line system. Copies of lifestyle plans are available for care staff. The residents and family interviewed confirmed they were involved in the care planning and review process. Short term care plans are in use for changes in health status.

The activity staff provide an activities programme for residents in the rest home, hospital and dementia unit that is varied, interesting and involves the families and community.

Staff responsible for medication administration have completed annual competencies and education. There are three monthly GP medication reviews.

Meals are prepared on site. The menu is designed by a dietitian with summer and winter menus. Individual and special dietary needs are catered for. Residents interviewed responded favourably to the meals provided.

## 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. |  | Some standards applicable to this service partially attained and of low risk. |

Village at The Park Lifecare has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by authorised technicians.

Residents’ rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner’s room.

The service has implemented policies and procedures for civil defence and other emergencies. Six monthly fire drills are conducted. The call bell system did not provide dual access plugs in two rooms, and has been identified as a required improvement.

External garden areas are available with suitable pathways, seating and shade provided. The dementia unit is secure with easy access to a secure outdoor area.

This audit has assessed three rooms in the hospital as suitable for hospital level care.

## 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. |  | All standards applicable to this service fully attained with some standards exceeded. |

There is a restraint policy that includes comprehensive restraint procedures. The service currently has one resident assessed as using a restraint and one resident using an enabler. There has been a significant reduction in restraint use which has resulted in a rating of continuous improvement.

Staff are trained in restraint minimisation and restraint competencies are completed regularly.

## Infection prevention and control

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| --- | --- | --- |
| 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. |

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. Documented policies and procedures are in place for the prevention and control of infection and reflect current accepted good practice and legislative requirements. Infection control education is provided to all service providers as part of their orientation and also as part of the on-going in-service education programme. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Results of surveillance are acted upon, evaluated and reported to relevant personnel. The service has implemented recommendations from regional public health.

## Summary of attainment

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 2 | 47 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 2 | 98 | 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)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Information on the Code of Health and Disability Consumers’ Rights (the Code) is displayed in visible locations. Policy relating to the Code is implemented and staff can describe how the Code is implemented in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with all care staff including seven caregivers, four registered nurses (RNs), three activities assistants, and three care managers/RNs reflected their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | Informed consent processes were discussed with residents and families on admission. Written general and specific consents were evident in the ten resident files sampled (two rest home, four hospital and four dementia). Care staff interviewed confirm consent is obtained when delivering cares. Resuscitation orders for competent residents were appropriately signed. The general practitioner (GP) discusses resuscitation with families/EPOA where the resident is deemed incompetent to make a decision. Discussion with family members identified that the service actively involves them in decisions that affect their relative’s lives. All ten admission agreements sighted were signed within the required timeframe. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the Health and Disability Commissioner’s (HDC) Office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. Residents have access to and participate in various community services if able. The service encourages the residents to maintain their relationships with their friends, and community groups by continuing to attend functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to residents and relatives at entry to the service. Access to complaints forms and a suggestions box are located at reception. The complaints form includes contact details for the HDC Advocacy Service. A record of all verbal and written complaints received is maintained by the general manager (GM) using a complaints’ register. Documentation including follow up letters and resolution demonstrates that complaints are well-managed. Eight complaints were received in 2014 and one in 2015 year-to-date with evidence of appropriate and timely follow-up actions taken. All of the complaints received in 2014 have been resolved. An action plan is being implemented for the complaint received in 2015.Discussions with residents and relatives confirmed they were provided with information on complaints.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Details relating to the Code and the Health and Disability Advocacy Service are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The registered nurse (RN) discusses aspects of the Code with residents and their family on admission. All seven residents (two rest home level and five hospital level) and ten relatives (four dementia level and six hospital level) interviewed report the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code and its application to aged residential care. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service ensures that the residents’ right to privacy and dignity is recognised and respected at all times. The residents’ personal belongings are used to decorate their rooms. All rooms were single occupancy during the audit. Adequate space is available for discussions of a private nature. The caregivers interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. They report that they support the residents' independence by encouraging them to be as active as possible. All of the residents interviewed confirmed that their privacy is being respected. Guidelines on abuse and neglect are documented in policy. Staff receive education and training on abuse and neglect. Any suspected instances of abuse or neglect by staff are dealt with in a prompt manner by the general manager. |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered within the service. The facility is located on Tenths Trust land. Links are established with the Wellington Tenths Trust with members from the Trust represented on the board. Staff value and encourage active participation and input of the family/whanau in the day-to-day care of the resident. During this audit there were three Maori residents living at the facility, two in the dementia unit and one in the rest home. The Maori resident in the rest home was interviewed and reports that her needs are being met by the service. Identified cultural needs are documented in the residents’ care plans. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All care staff interviewed are aware of the importance of whanau in the delivery of care for Maori residents.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The facility’s residents are from a variety of cultures. The service identifies the residents’ personal needs, values and beliefs, and desires from the time of admission and incorporates this information into the residents’ lifestyle plans. This is achieved with the resident, family and/or their representative. The service is committed to ensuring that each resident remains a person, even when their health status alters. All residents and relatives interviewed confirmed they were involved in developing the resident’s lifestyle plan. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The Code of Conduct discussed and signed during the new employee’s induction to the service. Professional boundaries are defined in job descriptions. Interviews with all care staff confirmed their understanding of professional boundaries including the boundaries of the caregivers’ role and responsibilities. The RNs are supported to complete the Professional Development Recognition Programme through the New Zealand Nursing Council. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | CI | Registered nursing staff are available seven days a week, 24 hours a day. A general practitioner (GP) visits the facility twice a week. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits scheduled for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided.Quality initiatives implemented since the last audit include establishing links with Massey University to promote evidenced based practice, with a research partnership, investigating opportunities to enhance the induction programme for its culturally diverse RN staff, and implementing strategies which have led to the reduction of falls and challenging behaviours in the dementia unit. They are in the process of fully implementing the Spark of Life Programme which has included training the general manager (GM) to master practitioner, training facilitators, and the development of a club programme for the residents. In the dementia unit staffing levels have increased, staff uniforms have changed, and the environment enhanced to create a more homelike environment. Families are engaged in learning opportunities relating to the Spark of Life. The service receives support from Capital and Coast District Health Board which includes visits from the mental health team, and nurse specialists. Physiotherapy services are provided four hours per week. A podiatrist is onsite every two weeks. The service has links with the local community and encourages the residents to remain as independent as possible. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whanau is documented on accident/incident forms and in the residents’ progress notes. Fifteen accident/incident forms that were reviewed across the rest home, hospital and dementia unit identified family are kept informed. All of the relatives interviewed stated that they are kept informed when their family members health status changes. An interpreter policy and contact details of available interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. An iPad is available to use as a tool for translation.Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay that are not covered by the agreement.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The Village at the Park Lifecare facility is located in Wellington. It is one of four care facilities owned by Hurst Lifecare Limited. The service currently provides care for up to 92 residents at hospital, rest home, and dementia levels of care with 85 residents living at the facility during the audit. On the day of the audit there were 42 hospital residents, 11 rest home residents including one resident living in a serviced apartment and 32 residents residing in the secure dementia unit. Hurst Lifecare Limited has an organisational philosophy, which includes a vision, mission statement and objectives. Village objectives for The Village at the Park Lifecare are linked to the organisation’s strategies, are regularly reviewed and are updated each year. Clinical and operational key performance indicators have been determined. The general manager is a registered nurse who has been in this role for over four years. Prior to this appointment she was a programme manager at ACC with clinical, residential, and disability service portfolios. She has a Masters in Health Service Management from Massey University. The general manager is supported by three care managers. A national quality advisor was appointed in November 2014.The general manager has maintained over eight hours annually of professional development activities related to managing an aged care facility.  |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | The assistant manager is also the care manager for the secure dementia unit. She is an RN and has a signed job description which outlines responsibilities as the assistant manager and has worked at the facility for over four years. |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | An established quality and risk management system is being maintained. The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A system for document control is in place. Any new policies or changes to policy are communicated to staff, evidenced in meeting minutes and in interviews with staff (seven caregivers, four RNs, three activities assistants, two kitchen staff, three cleaning/laundry staff and two maintenance staff).Key components of the quality management system include (but are not limited to) monitoring falls, medication errors, restraint use, pressure areas, infections, wounds and resident satisfaction. Monthly reports submitted to the national quality advisor and the chief executive officer provide a coordinated process between service level and the organisation. There are monthly accident/incident reports that break down the data collected across the rest home, dementia unit, hospital units and staff incidents/accidents. Falls prevention strategies are in place that includes the analyses of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The internal audit programme monitors key components of the service. If a target is not met or an area of noncompliance is identified, there is evidence of a corrective action plan. A comprehensive health and safety programme in place with strategies implemented to promote staff wellness. The service has WSMP ACC – tertiary level. |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | Individual incident reports are documented for each incident/accident and are also documented in the residents’ progress notes. Documentation includes the action taken and any follow up action required. Data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Residents’ falls and episodes of challenging behaviours are trending downward in the secure dementia unit (link to 1.1.8.1). Fifteen completed incident forms were reviewed and reflected a clinical assessment and follow up by a registered nurse. Discussions with the general manager and care managers confirms their awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. The staff files that were reviewed (five caregivers, three RNs, cleaner, kitchen assistant) included evidence of the recruitment process, signed employment contracts, police vetting, and completed orientation programmes and annual performance appraisals. The orientation programme provides new staff with relevant information for safe work practice. Competencies are completed specific to worker type. Staff interviewed stated that they believed new staff were adequately orientated to the service.A register of current practising certificates for all health professionals is maintained.There is an annual education schedule that is being implemented and covers up to two study days annually per employee. In addition, opportunistic education is provided. Aged Care Education (ACE) is required for the caregivers. Education for RNs is supported by the Capital and Coast District Health Board. Discussions with staff and management confirmed that a comprehensive education and training programme in relevant aspects of care and support is in place. There are twenty caregivers who work in the dementia unit. Ten of the caregivers have completed the required dementia ACE programme. Ten staff have been employed for less than one year and are enrolled in the programme.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. The GM is an RN with a current practising certificate. Two care managers/RNs are assigned to the dementia and hospital wings and one care manager/enrolled nurse (EN) is assigned to the rest home wing. An RN is available on site 24 hours a day, seven days a week. Caregivers are adequately staffed throughout the facility. Staffing is flexible to meet the acuity and needs of the residents. A casual pool of staff is available as needed. Agency staff have not been used for three years. Interviews with seven residents and ten families confirmed staffing overall was satisfactory. |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. An initial support plan is also developed in this time. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held in a secure room. Archived records are secure in separate locked and secure areas.Residents’ files demonstrate service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse including designation. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has comprehensive admission policies and processes in place. Residents receive an information booklet around admission processes and entry to the service. All residents have a current needs assessment prior to entry to services to confirm they meet the level of care provided at the facility. Residents and relatives interviewed confirmed they received information prior to admission and discussed the admission process and admission agreement with the general manager. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | Transfer information was completed by the registered nurse or care managers and communicated to support new providers or the receiving health provider. The information meets the individual needs of the transferred resident. Registered nurses interviewed could describe the required transfer documentation including the yellow envelope system used by the district health board. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there was a change in the resident's condition. |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | All medication is managed appropriately in line with required guidelines and legislation. Registered nurses and senior caregivers responsible for the administering of medication complete annual medication competencies and attend annual medication education. The service uses individualised medication packs for regular and as required medications. Medications are checked on delivery by registered nurses against the medication chart. All medication trollies contents were all within expiry dates and all eye drops were dated on opening. There was one rest home and one hospital self-medicating residents, competency was documented and reviewed by the GP three monthly, and there is a procedure for monitoring of self-medication. Medication administration practice was observed to be compliant. As required medications have the date and time of administration on the signing sheet. A separate chart logs and monitors each use of as required medications for each individual resident. As required medications are supervised by registered nurses. Twenty medication charts sampled all met legislative prescribing requirements. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | The service employs a qualified chef and a cook. They are supported by three kitchen hands each day. There is a five weekly seasonal menu that had been designed and reviewed January 2015 by a dietitian. The chef or cook receives a resident dietary profile for all new admissions and was notified of dietary changes following the three/six monthly review and at other times such as resident with weight loss/weight gain or swallowing difficulties. The chef/cook meets monthly with the dietitian to discuss resident’s dietary requirements. Specific cultural preferences were met. Resident likes, dislikes and dietary preferences were known. There were two meal options identified on the menu for the evening meal. Food is delivered in hot boxes to each of the three dining areas. Staff were observed sitting with the residents when assisting them with meals. The service is well equipped. The freeze/fridge temperatures were checked twice daily. Food temperatures are monitored twice daily and recorded. All foods were date labelled. A cleaning schedule is maintained. Feedback on the service was received from resident and staff meetings, surveys, communication books and audits. The chef personally met with residents and relatives to gain feedback about the food service or to discuss individual dietary requirements. Staff have been trained in safe food handling and chemical safety.The service provides additional nutritious snacks available over 24 hours readily available for residents in the dementia unit. |
| 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.  | FA |  The service records the reason for declining service entry to residents should this occur and communicates this to residents/family/whanau. Anyone declined entry was referred back to the needs assessors or referring agency for appropriate placement and advice. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All appropriate personal needs information is gathered during admission. Risk assessment tools including InterRAI assessments were sighted as completed and reviewed at least three monthly in the hospital and rest home and six monthly in the dementia unit or when there was a change to a resident’s health condition. Lifestyle plans reflected the outcome of the risk assessments for the 10 resident files sampled.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long term lifestyle care plan includes nursing diagnosis, actual or potential/deficits, outlined objectives of nursing care, setting goals, and details of implementation. Resident/family/whanau involvement in the care planning process was evidenced by signatures on the written acknowledgment of care plan form in the resident files sampled. Residents and relatives interviewed confirmed they were involved in their lifestyle plans. Short term care plans were in use for changes in health status. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents interviewed reported their needs were being met. Relatives interviewed stated their relative’s needs were being appropriately met. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. Faxes to the GPs for residents change in health status were sighted in the resident’s files.Dressing supplies are available and treatment rooms in all three areas are adequately stocked for use. Wound assessment, wound treatment and evaluations including frequency for one chronic wound, was linked to the long term lifestyle plans. Pressure area cares (grade I) for one resident and interventions were documented in the long term lifestyle plans. The RNs interviewed have access to an external wound specialist as required. The GP reviews the wounds three monthly or earlier if required. Continence products are available and resident files included a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the registered nursing staff interviewed. Monitoring forms in place include (but not limited to); monthly weight, blood pressure and pulse, food and fluid charts, restraint, blood sugar levels, behaviour charts and as required medications. |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities staff provide an activities programme over five days each week. The activity plan is reviewed by a contracted part time Occupational Therapist. There are two Spark of Life Club facilitators and one activity assistant employed. There are activities planned for the weekend that are delivered by caregivers. Caregivers in the dementia unit have been orientated to activities and deliver the planned programme over the weekend. The programme is planned monthly and residents receive a personal copy of planned monthly activities. Activities planned for the day were displayed on notice boards around the facility. An activity plan is developed for each individual resident based on assessed needs. A 24 hour activity plan was developed for all residents in the dementia unit. Residents were encouraged to join in activities that were appropriate and meaningful and were encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered to all residents.One of the quality initiatives for 2014/15 is to roll out the Spark of Life philosophy at the service. The general manager has attended a spark of life programme in November 2014 and is now a Master Practitioner for Spark of Life. An activity assistant is scheduled to complete the facilitator training in February 2015. The new model of care involves shifting care delivery from a clinical focus to a social focus. In the dementia unit, this has involved increasing activity hours, with the introduction of a Spark of Life resident’s sunshine club (commenced February 2015). The sunshine club involves regular small group resident meetings. The residents are of similar cognition and are facilitated by the spark of life facilitator (# link 1.1.8.1).  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Lifestyle care plans reviewed were updated as changes were noted in care requirements. Lifestyle plan evaluations are comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short term care plans are utilised for residents and any changes to the long term care plan were dated and signed. Lifestyle plans are evaluated within the required time frames.  |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.  | FA | The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The care managers (RN) and RN's interviewed state they initiate referrals to nurse specialist services. Specialist referrals were made by the GP. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. Discussions with registered nurses identified that the service has access to appropriate allied health providers. The service provided examples of where a resident’s condition had changed and the resident was reassessed.  |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals were stored securely. Laundry and sluice rooms are locked when not in use. Manufacturers Data sheets were available and the hazard register identifies hazardous substances. Gloves, aprons, and goggles are available for staff. Safe chemical handling training has been provided. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness which expires on 23 March 2015. Hot water temperatures are checked weekly. Medical equipment and electrical appliances have been tested and tagged and calibrated. The service has a van used for resident’s outings that has a current warrant of fitness and registration. Regular and reactive maintenance occurs. Residents were observed to mobilise safely within the facility. There are sufficient seating areas throughout the facility. The exterior has been well maintained with safe paving, outdoor shaded seating, lawn and gardens. Caregivers interviewed confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the lifestyle plans.The dementia unit has several areas designed so that space and seating arrangement provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required including individual rooms. There is a safe and secure outside area that is easy to access.This audit confirmed three recently added rooms are suitable for hospital level care.  |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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. | FA | All bedrooms are single with ensuites. There are communal toilets located closely to the communal areas. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff are undertaking personal cares. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | The resident rooms, including three rooms assessed at this audit for dual purpose, are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. Caregivers interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms are personalised. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are lounges and dining rooms in the hospital, rest home and dementia areas. There are smaller quieter comfortable seating areas throughout the facility for residents and visitors. Dining rooms are spacious, and located directly off kitchen/server areas. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents interviewed report they were able to move around the facility and staff assisted them when required. Activities take place in any of the lounges.The dementia unit provides adequate space to allow maximum freedom of movement while promoting safety for those that wander. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Village at The Park Lifecare has monitored the effectiveness and compliance of cleaning and laundry policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by designated laundry staff. Staff have attended infection control and chemical education. There is appropriate protective clothing available. Manufacturer’s data safety charts are available. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the room/facility. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | PA Low | Emergency and disaster policies and procedures are in place. An approved the fire evacuation plan is in place, which includes approval for keeping the dementia unit locked with key access only. Fire evacuation drills take place every six months. The orientation programme and annual education and training programme include mandatory fire and security training. Staff interviews confirm their understanding of emergency procedures.Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. 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 cooking. Short-term back up power for emergency lighting is in place.The sensor mats are linked to the call bell system. Two residents with sensor mats did not have dual access to their hand held call bell. This is a required improvement.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal areas and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Residents and family interviewed stated the environment was warm and comfortable. |
| Standard 3.1: Infection control managementThere 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.  | FA | Village at The Park has an established infection control programme. The infection control (IC) programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident and quality reporting system. The care manager of the rest home and dementia unit is the designated infection control nurse with support from the hospital care manager, registered nurses and staff. IC is discussed monthly as part of the quality meeting. Minutes were available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | There are adequate resources to implement the infection control programme at the service. The infection control (IC) nurse has maintained her practice by attending infection control updates. The infection control team is representative of the facility and includes seven staff members. External resources and support have been available when required. Infection prevention and control has been part of staff orientation and induction. Hand washing facilities were available throughout the facility and sanitising hand gel was freely available. |
| Standard 3.3: Policies and proceduresDocumented 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. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies have been reviewed and updated at least two yearly. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The facility is committed to the on-going education of staff and residents. Education has been facilitated by the Infection Control coordinator and education coordinator. All infection control training has been documented and a record of attendance has been maintained. Visitors were advised of any outbreaks of infection and were advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that was appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2014 and January 2015. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The surveillance policy for infection control describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator/RN uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.Infection surveillance and monitoring is an integral part of the infection control programme and is described in infection monitoring policy. A registered nurse (care manager) is the designated infection control nurse. Monthly infection data is collected for all infections based on signs and symptoms of infection. A monthly log of Individual resident infection is completed which included signs and symptoms of infection, treatment, follow up, review and resolution. Surveillance of all infections was entered on to a monthly facility infection summary and staff were informed. The data has been monitored and evaluated monthly and annually at facility level, including benchmarking within the group and against national aged care indicators. An outbreak in October 2014 was appropriately managed, with notification to relevant authorities. The outbreak started 4 October 2014 and ended 26 October 2014. Forty eight residents and 13 staff were affected. The service contacted the district health board on 9 October 2014 when eight residents were affected. . The service completed appropriate documentation throughout the outbreak and completed a final report. The service received a report from the regional public health department with recommendations that have been implemented. A debriefing meeting was held with staff in November 2014 and recommendations were discussed and implemented. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregivers and nursing staff confirm their understanding of restraints and enablers. The service has one hospital-level resident using bedrail as an enabler. Enablers are assessed as required for maintaining safety and independence and are being used voluntarily by the resident. |
| Standard 2.2.1: Restraint approval and processesServices 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.  | FA | A restraint approval process is in place. A job description for the restraint coordinator is in place. The restraint coordinator role is delegated to a registered nurse. All staff are required to attend restraint minimisation training annually.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident’s lifestyle (care) plan, discussions with the resident and family and observations by staff. A restraint assessment tool is in place, which meets the requirements of the standard. One hospital level resident using a restraint (lap belt) during the audit had a restraint assessment and consent form completed. Restraint use was linked to the resident’s lifestyle plan.  |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | A restraint register is in place. The register identifies one hospital-level resident as using a lap belt as a restraint. The assessment identified that this restraint is being used only as a last resort. The restraint assessment and on-going evaluation of restraint use process includes reviewing the frequency of monitoring residents while on restraint. A completed monitoring form was sighted for the one resident using a lap belt. |
| Standard 2.2.4: EvaluationServices evaluate all episodes of restraint. | CI | Restraint use is reviewed three monthly by the restraint coordinator. The restraint coordinator reported that efforts were undertaken in 2014 to reduce the number of restraints that were in place. In January 2014, fifteen residents were using a restraint. A number of strategies were implemented to reduce restraint use. At the time of the audit, only one resident was using a restraint. This is an area of continuous improvement.  |
| Standard 2.2.5: Restraint Monitoring and Quality ReviewServices demonstrate the monitoring and quality review of their use of restraint. | FA | The restraint programme, including reviewing policies and procedures and staff education is regularly reviewed. The most recent review was conducted on 20 December 2014 and included the restraint coordinator, GM, RNs, EN and the GP. |

# 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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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.4.7.5An appropriate 'call system' is available to summon assistance when required. | PA Low | An electronic call system is in place, which is being monitored by the general manager. The sensor mats are linked to the electronic call system. If a dual cord is not in place, the sensor mat excludes access to a hand bell. Two residents visited during the audit had sensor mats in place. Their sensor mats had been placed under their beds and they were sitting up in their chair. They did not have access to a hand held call bell. The general manager reported that this could be quickly remedied and ordered additional dual purpose cords for the facility.  | During the audit, two residents sitting in chairs did not have access to a hand held call bell.  | Ensure all residents are able to summon assistance when required.60 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.1.8.1The service provides an environment that encourages good practice, which should include evidence-based practice. | CI | Registered nursing staff are available seven days a week, 24 hours a day. A general practitioner (GP) visits the facility twice a week. Residents identified as stable are reviewed by the general practitioner (GP) every three months with more frequent visits scheduled for those residents whose condition is not deemed stable. The GP interviewed is satisfied with the level of care that is being provided.Quality initiatives implemented since the last audit include establishing links with Massey University to promote evidenced based practice ,with a research partnership, investigating opportunities to enhance the induction programme for its culturally diverse RN staff, and implementing strategies which have led to the reduction of falls and challenging behaviours in the dementia unit. They are in the process of fully implementing the Spark of Life Programme, which has included training the general manager (GM) to master practitioner, training facilitators, and the development of a club programme for the residents. In the dementia unit staffing levels have increased, staff uniforms have changed, and the environment enhanced to create a more homelike environment. Families are engaged in learning opportunities relating to the Spark of Life. The service receives support from Capital and Coast District Health Board which includes visits from the mental health team, and nurse specialists. Physiotherapy services are provided four hours per week. A podiatrist is onsite every two weeks. The service has links with the local community and encourages the residents to remain as independent as possible. | Quality initiatives implemented since the last audit include establishing links with Massey University to promote evidenced based practice, with a research partnership, investigating opportunities to enhance the induction programme for its culturally diverse RN staff, and implementing strategies which have led to the reduction of falls and challenging behaviours in the dementia unit. They are in the process of fully implementing the Spark of Life Programme which has included training the general manager (GM) to Spark of Life master practitioner, training facilitators, development of a club programme for the residents. In the dementia unit, staffing levels have increased, staff uniforms have changed, and the environment enhanced to create a more homelike environment. Families are engaged in learning opportunities relating to the Spark of Life.  |
| Criterion 2.2.4.1Each episode of restraint is evaluated in collaboration with the consumer and shall consider:(a) Future options to avoid the use of restraint;(b) Whether the consumer's service delivery plan (or crisis plan) was followed;(c) Any review or modification required to the consumer's service delivery plan (or crisis plan);(d) Whether the desired outcome was achieved;(e) Whether the restraint was the least restrictive option to achieve the desired outcome;(f) The duration of the restraint episode and whether this was for the least amount of time required;(g) The impact the restraint had on the consumer;(h) Whether appropriate advocacy/support was provided or facilitated;(i) Whether the observations and monitoring were adequate and maintained the safety of the consumer;(j) Whether the service's policies and procedures were followed;(k) Any suggested changes or additions required to the restraint education for service providers. | CI | In January 2014, fifteen residents were using a restraint. Each resident was re-evaluated to determine their need for a restraint. A number of strategies were implemented which included purchasing guard mattresses, fallout mattresses and sensor mats. Families were kept informed. Restraint use was reduced to one hospital resident. | Restraint use is reviewed three monthly by the restraint coordinator. The restraint coordinator reported that efforts were undertaken in 2014 to reduce the number of restraints that were in place. In January 2014, fifteen residents were using a restraint. A goal was set by the organisation to provide a restraint free environment. The plan of action to achieve this goal included: 1) review/re-assessment of residents who are currently on restraint/enabler; 2) exploring alternatives to restraint/enabler use through evidence-based research; 3) Procurement of alternative equipment for falls prevention as opposed to using bedrails; 4) Staff, residents and family education around restraint minimisation and 5) Seeking advice from key personnel in the implementation of alternative measures. The time frame to achieve the goal was February - April 2014.Implementation included the following: 1) Bedrails were substituted with a guard mattress, fall out mattress and sensor mat as falls prevention strategies 2) Residents were monitored without the use of restraint on a regular and continuous basis until they were deemed safe without a restraint 3) Feedback was given to family members 4) Residents who were previously using bedrails as an enabler were offered bed handles to help them get in and out of bed 5) Education was provided to staff around restraint minimisation and 6) regular monitoring and follow through was conducted on daily handover. During evaluation of the strategies that were implemented, restraint and enabler use has significantly reduced. There has been no increase in the incidence of falls with the introduction of this programme.  During the audit only one resident was using a restraint (lapbelt) and one resident was using an enabler. This is an area of continuous improvement. |

End of the report.