

# Oceania Care Company Limited - Atawhai Lifestyle Care & Village

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## 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Atawhai Lifestyle Care & Village
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 4 March 2015    End date: 5 March 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	79

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Atawhai Lifestyle Care & Village (Oceania) can provide care for up to 82 residents requiring rest home or hospital level of care. 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 they are 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

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 were treated with respect and received services in a manner that considered their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint was available to residents and their family.

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

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

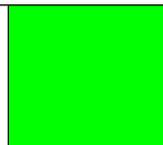
Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. These are used to provide comparisons with other Oceania facilities.

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

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.

Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a care guide for all staff, while the person centred care plan is developed over the first three weeks of admission. Reviews confirmed that care plans were individualised, risk assessments completed and residents' responses to treatment were evaluated and documented. Where the progress of a resident was not in line with expected outcomes the service changed the person centred care plan to facilitate the changed needs of the resident. Care plans are evaluated six monthly. Relatives are notified regarding changes in a resident's condition.

During the onsite audit the recreational activities were appropriate to the age, needs and culture of the residents and supported their interests and strengths. The residents and families interviewed expressed being satisfied with the activities provided by the diversional therapists.

Medicine management policies and procedures are documented as part of their quality system and the medication processes and practices are in line with the legislation and contractual requirements. Medication charts were reviewed and evidenced the general practitioner completed regular and timely medical reviews of residents and medicines. Medication competencies were completed annually for all staff that administered medications. All residents who self-administered medicines at the time of the audit had assessments, and competencies signed off by the registered nurse and the general practitioner.

Food, fluid and nutritional needs of residents are provided in line with nutritional guidelines and are appropriate to the age group. The menus have been reviewed by the dietitian.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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All building and plant complies with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks. The environment is appropriate to the needs of the residents. Fixtures, fittings and 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 allowed residents to access help when needed in a timely manner.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint and enabler use were the least restrictive option to ensure resident's safety and independence. The restraint register was current.

Policies and procedures comply with the standard for restraint minimisation and safe practice. Reviewed files confirmed that risk assessments, documentation, monitoring and reviews were identified, recorded and implemented for all restraints used in the facility. Staff members received adequate training regarding the management of challenging behaviour and restraint use. Restraint competencies were current at the time of the on-site audit.

## 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 is conducted according to the education and training programme and recorded in staff files.

Infections are investigated as part of the quality programme and appropriate antibiotics were prescribed according to sensitivity testing. Data relating to infections are collected monthly for benchmarking. Appropriate interventions are in place to address infections. 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)
<b>Standards</b>	0	50	0	0	0	0	0
<b>Criteria</b>	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: 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 have had training in 2014.</p> <p>Interviews with the staff confirmed their understanding of the Code.</p> <p>Examples were provided 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 included how to make a complaint, 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> <p>Consumers and where appropriate their family/whānau of</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. Staff ensure that all 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. All resident files identified that informed consent was collected.</p>

<p>choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>Interviews with staff confirmed their understanding of the informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discuss informed consent processes with residents and their families/whānau during the admission process.</p> <p>The policy and procedure includes 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 being acknowledged. Resident information around advocacy services was available at the entrance to the service.</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/whānau and chosen social networks with a communication sheet kept on the resident file and completed when family visit.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their 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 visitors can arrange to visit after doors are locked.</p> <p>Families interviewed confirmed they could visit at any time and were always made to feel welcome. There is a whānau/family room with a fold out couch and lazy boy. The room can be used for family who are wish to stay overnight.</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</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures is in line with the Code and includes periods for responding to a complaint. Complaint forms were available at the entrance.</p> <p>A complaints register was in place and the register included the date the complaint was received; the</p>

<p>a complaint is understood, respected, and upheld.</p>		<p>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 discuss 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> <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 was also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.</p> <p>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 and respect and quality of life.</p> <p>The service has policies and procedures that align 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 names 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 has 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 – observed on the days of the audit. Residents and families interviewed confirmed the residents' privacy was respected.</p> <p>Health care assistants interviewed reported that they encouraged the residents' independence by encouraging them to be as active as possible.</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 were aware of the signs of abuse and neglect on interviews.</p> <p>Resident files reviewed identified that cultural and /or spiritual values and individual preferences were 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 the 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 are staff who 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 are 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>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual 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 representative.</p> <p>There is a culture of choice with the resident determining when cares occur, times for meals, choices in meals, choices in activities etc. 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>While there were two residents who spoke English as a second language, neither required support from an interpreter or identified any specific cultural support.</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>Atawhai 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 the Oceania facilities.</p> <p>There is a training programme for all staff and managers are 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 and a dietitian.</p> <p>The key projects implemented in the past year include the following: improvements to the orientation programme; a more innovative and creative activities programme; a focus on team work and raising of satisfaction with food services by 23%.</p> <p>The service has no corrective actions as a result of this audit and has focused on achieving results and outcomes for residents through a robust form of monitoring and analysis of data. The service has reduced the number of complaints by 65% since 2013 noting that this has not stopped residents and others being able to make a complaint if they choose to. The service had also focused on improving communication between managers, staff, residents and family with data to be collated around this.</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/incident, 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 change in needs, as evidenced in completed accident/incident forms.</p> <p>Family contact was recorded in the residents' files reviewed. 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 were available from the district health board. There were no residents requiring interpreting services. Staff were able to describe interpreting body language and sounds for one resident who was non-verbal with the family identified as a key advocate for the resident.</p> <p>The information pack is available in large print and this could be read to residents.</p> <p>Staff had 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. All were signed on the day of admission.</p> <p>The business and care manager distributes a three monthly newsletter specifically related to Atawhai for residents and family, Connect (Oceania wide) newsletters are distributed monthly to residents and other stakeholders.</p>

<p><b>Standard 1.2.1: Governance</b></p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Atawhai 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. The operations manager, senior clinical and quality manager and the clinical and quality manager provided support during the audit.</p> <p>Oceania has a clear mission, values and goals. These were 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 82 residents with 14 identified rest home beds. During the audit there were 79 residents living at the facility including 29 residents requiring rest home level of care and 49 residents requiring hospital level of care. The service also has a contract to provide intermediary care with three beds potentially allocated for residents requiring these. One was occupied on the day of the audit with any referrals overseen by the geriatrician.</p> <p>The business and care manager is responsible for the overall management of the facility, had been in the role for two years with over 15 years operational and business management experience.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>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.</p>	<p>FA</p>	<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 appointed into the role in the last month, had eight years' experience as a clinical manager and a facility manager for one year. The clinical manager is a registered comprehensive nurse with over 10 years' experience in aged care. Health CERT had been informed of the appointment of the clinical manager.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	<p>FA</p>	<p>Atawhai uses the Oceania quality and risk management framework that is documented to guide practice. The operations and business brief 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 reviewed 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 are readily</p>

<p>principles.</p>		<p>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 understood.</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 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 were also resident meetings that kept residents informed of any changes. Staff reported that they were kept informed of quality improvements.</p> <p>There was 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 is 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>
<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 would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There were 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 understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Fifteen 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</p>	<p>FA</p>	<p>The registered nurses and the clinical manager have current annual practising certificates along with</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>other health practitioners involved with the service.</p> <p>Staff files included: appointment documentation; signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place. First aid certificates were held in the staff files.</p> <p>All staff complete an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including personal cares. Staff interviewed confirmed the review of the orientation programme with a new staff member stating that there was a robust process.</p> <p>Annual competencies were completed by care staff and included: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar and insulin; and assisting residents to shower. The organisation has a mandatory education and training programme. Staff attendances are documented. Education and training hours were 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>At the time of the audit, there were 90 staff including 11 registered nurses, a diversional therapist and 48 health care assistants. There were two registered nurses on each morning and afternoon with at least one other registered nurse or enrolled nurse on in the morning in the rest home area. There was one registered nurse on duty overnight. The business and care manager and clinical manager were on call.</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 is sufficient detail in resident files to identify residents' ongoing care history and activities.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files and relevant resident care and support information could be accessed in a timely manner.</p> <p>Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other</p>

		<p>staff member including designation.</p> <p>Resident files are protected from unauthorised access by being locked away in an office.</p> <p>Information containing sensitive resident information was not displayed in a way that could be viewed by other residents or members of the public on day of audit. Individual resident files demonstrate service integration. This includes medical care interventions. Medication charts are in a separate folder with medication.</p>
<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 resident files reviewed, and kept securely in the administration office. The facility requires all residents to have a Needs Assessment Service Coordinators (NASC) assessments prior to admission to ensure they are able to meet the resident's needs. The registered nurses (RNs) admit new residents into the facility, confirmed during interview. Completed admission records were sighted. The RNs receive hand-over from the transferring agency, for example the hospital and utilise the information in creating the appropriate initial and then 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>Service providers identified, documented and minimised risks associated with each resident's transition, exit, discharge and or transfer. This included expressed concerns of the resident and the family as confirmed during the on-site audit. The service uses a specific transfer form to document areas of potential risk which includes personal details of the resident, risk assessment information, the person centred care plans and a copy of the medicines chart and administration record.</p> <p>There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The service includes copies of the resident's records; GP visits; medication charts; 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</p>	FA	<p>Visual inspection of the medication areas evidenced appropriate and secure medicine administration systems. The medicines management rooms were free from heat, moisture and light, with medicines stored in original dispensed packs, in a locked medicines trolley.</p> <p>Medicines charts sampled, listed all medications the resident was taking, including name, dose, frequency and route to be given. Charts were signed by the GP. All entries were dated and allergies</p>

<p>requirements and safe practice guidelines.</p>		<p>recorded. All charts had photo identification. Discontinued medicines were signed and dated and three monthly GP reviews were evident. All medicines were prescribed by the GPs using pharmacy generated medication administration charts. Medication reconciliation policies and procedures were implemented. Controlled drugs were kept inside a locked cupboard and the controlled drugs register was current and correct. Sharps bins were sighted. Unwanted or expired medications were collected by the pharmacy.</p> <p>Medication administration rounds were observed during lunch time. The staff members checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines and then signed off after the resident took the medicines. Education in medicine management was conducted annually. Staff were authorised to administer medications. This includes completion of a medication competency test and practical round. Self-administration of medicine policies and procedures were in place and sighted. There were three residents who self-administered medicines.</p> <p>Medication fridges were monitored regularly.</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>Food policies, procedures and services are appropriate to the service setting, providing summer and winter menus that rotate every four weeks. The menu was developed by a dietitian. This was confirmed by the cook during interview. Food procurement, production, preparation, storage and disposal comply with requirements. Stored food was sighted. The cook kept daily records of fridge, freezer and chiller temperatures and records were sighted. Food temperatures were monitored and records maintained. All kitchen staff completed food safety training.</p> <p>Resident's individual dietary needs were identified, documented and reviewed as part of the long term care plan review. The cooks and /or chef were informed when residents' dietary needs changed. This was confirmed during interview and sighted in copies of dietary assessments.</p> <p>Additional food and snacks were available. This was confirmed during resident and family interviews. Residents were offered fluids throughout the day. Residents' files sampled demonstrated monthly monitoring of individual resident's weight. Family surveys confirmed they were satisfied with food services.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to</p>	<p>FA</p>	<p>Atawhai has a documented process for the management of declining resident's 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 scope of services provided is identified in the admission agreement and communicated to</p>

<p>the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		<p>prospective residents and their families. This was confirmed during the interview with residents and their family.</p> <p>The clinical manager (CM) assesses the suitability of residents and uses an enquiry form with appropriate questions regarding the specific needs and abilities of the resident.</p> <p>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</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Resident files reviewed evidenced risk assessments for the identification of residents' needs. Initial care plans were completed on admission, signed by the registered nurse and by the resident or their family. This was confirmed in staff and resident interviews. Needs, outcomes and goals in the long term care plans were consistent to the needs, goals and outcomes in the risk assessments. Assessments are conducted in a timely manner and risk assessment findings are reflected in the long term care plans.</p> <p>Baseline recordings are recorded for weight management and vital signs with monthly monitoring. Staff interviews confirmed that the families were involved in the assessment and review processes. The outcomes of the assessments are used in creating an initial care plan, the PCCP and a recreational plan for each resident.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The PCCPs reviewed were resident focused, integrated, and promoted continuity of service delivery. An initial plans of care were developed on admission while the PCCPs were 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 allied health providers write their own care notes in the resident's files.</p> <p>The resident files are comprehensive and easy to use. 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>There was evidence that the clinical care, treatment, support and interventions provided were current in the resident files reviewed. The GP was responsible for the care of the majority of the residents. This was confirmed during interview. The GP confirmed satisfaction with the level of care provided.</p>
<p>Standard 1.3.6: Service</p>	<p>FA</p>	<p>Residents receive adequate and appropriate services meeting their assessed needs and desired</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>outcomes. Interventions were documented for each goal as identified in the PCCPs. Other considerations like pain management, dietary likes and dislikes, appropriate footwear and walking and hearing aids were included in the PCCPs.</p> <p>Interview with the GP confirmed clinical interventions were effective and appropriate. Interventions from allied health providers were included in the PCCP this included; the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist. Documentation and observations made of the provision of services and/or interventions, demonstrated that consultation and liaison was occurring with other services. Referrals to other agencies were sighted in resident files. Visual inspection evidenced that there were adequate continence and dressing supplies. 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>
<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 facility employs a diversional therapist (DT) for the development, implementation and review of the activities programmes. The programmes confirmed that independence was encouraged and choices were offered to residents. The DT provided different activities addressing the abilities and needs of residents in the hospital and rest home, including additional activities for residents who were younger than 65. The service had three residents under the age of 65. Sufficient equipment was provided. Activities attendance records were maintained and resource materials were accessible for the staff to utilise.</p> <p>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 had their own copy of the programme.</p> <p>On admission the DT completes a recreation assessment for each resident. The recreation assessments are comprehensive. The DT provides the RNs with the recorded assessments to ensure it is included in the PCCPs. Review of activity plans are completed every six months, as part of the multi-disciplinary review, or when the condition of the resident changes. All resident files reviewed during the onsite audit had current activity assessments in place.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive</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 are completed by the HCAs and RNs. Progress notes reflect daily response to interventions and treatments. Short term care</p>

<p>and timely manner.</p>		<p>plans are developed for acute problems for example: infections; wounds; falls and other short term conditions. Changes to care are documented and residents are assisted in working towards goals.</p> <p>Additional reviews included the three monthly medication reviews by the GP and review and medicines re-conciliation when residents enter the service from another health provider. Evaluations are documented, resident focussed and indicate the degree of response to interventions and the progress towards meeting the resident's goals.</p>
<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>Resident documentation and records sampled confirmed that residents had choices regarding access and referrals to other health or disability services. Referral forms and letters to nursing and medical specialists were sighted. This included letter to the needs assessment team and specialist services at the Hawkes Bay District Health Board (HBDHB).</p> <p>The service maintained effective communication with family and resident representatives. This was confirmed during resident and family interviews and supported in resident records such as progress notes. The GP confirmed involvement in the referral processes. The service followed 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 were in place and incidents were reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets were available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>There was provision and availability of protective clothing and equipment that was appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear; and masks. Clothing was 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</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed – expiry date 1 August 2015. There have been no building modifications since the last audit.</p> <p>There was a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is an annual test</p>

<p>environment and facilities that are fit for their purpose.</p>		<p>and tag programme and this is up to date with BV Medical checking and calibrating clinical equipment annually.</p> <p>Interviews with staff and observation of the facility confirmed there was adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and 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>	<p>FA</p>	<p>There are adequate numbers of accessible toilets/bathing facilities. Rest home 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 are sufficient toilets and showers.</p> <p>Auditors observed residents being supported to access communal toilets and showers in ways that were respectful and dignified.</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>	<p>FA</p>	<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>Rooms could be personalized with furnishings, photos and other personal adornments and the service encouraged 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>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate,</p>	<p>FA</p>	<p>The service has lounge/dining areas including areas that could 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>and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>Dining areas are located on each floor and residents can choose to have their meals in their room.</p> <p>There is a staggered approach to lunch with hospital residents who require support to eat their meals having the first opportunity to access the dining room. This enables staff to focus on supporting residents in a meaningful relaxed manner.</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>Laundry is completed on site with the service providing laundry services for a total of three sites. The laundry services are operated by a separate company – Hawkes Bay Central Laundry. 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 were required 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 with cleaners providing duties seven 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 are in appropriately labelled containers. Ecolab products were used 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 is approved by the New Zealand Fire Service on 10 February 2006. 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 equipment had been checked within required timeframes.</p> <p>There is a diesel generator that is able to provide support for emergency services such as lighting.</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 utilised 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. A certificate of compliance for the call bells is completed annually with this last approved in</p>

		<p>July 2014.</p> <p>The doors are locked in the evenings. Staff complete a check in the evening that confirm that security measures had 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. There is a designated external smoking area.</p> <p>Family and residents interviewed confirmed the facilities were maintained at an appropriate temperature.</p> <p>A boiler is checked monthly to ensure that services were appropriately provided.</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 infection control program is maintained and updated by the organisation. During the on-site audit the infection control coordinator (ICC) was one of the registered nurses. The ICC was interviewed and reported that the responsibilities included monitoring and surveillance of infections on a monthly basis, collating the information and reporting to management. The infection control coordinator had a defined role description identifying the responsibilities if the ICC.</p>
<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>Infection control meetings were held as part of the staff meeting, this was confirmed during review of the meeting minutes and interview of the infection control coordinator (ICC). The ICC was responsible for the implementation of the infection control programme.</p> <p>Signs relating to hand washing processes were displayed in the nurses' station and at hand-basins. The infection control coordinator kept an infection control resource folder to assist in infection control training and implementation of the programme. Staff members interviewed confirmed their participation in infection prevention and control within the facility.</p> <p>Interview with the infection control coordinator confirmed surveillance was carried out in accordance with the service's infection control policies. The management of infections included residents having short term care plans. This was confirmed in resident records sighted.</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>	<p>FA</p>	<p>Policies and procedures for the prevention and control of infection comply with relevant legislation and current accepted good practice. The infection control policy and programme are reviewed annually. This was evident and confirmed during interview with the infection control coordinator. The service has access to micro-biologists at the laboratory and the infection control nurse specialist at the Hawkes Bay District Health Board (HBDHB) if required.</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>	<p>FA</p>	<p>A review of the education folders confirmed that infection prevention and control training was provided annually. Training included hand hygiene processes. Interviews with residents and family members confirmed they were aware of the importance of hand washing and the use of alcohol gels. The service offered education and training regarding hand washing procedures to residents in an informal manner during service delivery. The infection control coordinator completed additional infection control training specific to the role.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The ICC 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 reflects the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control coordinator. Surveillance for infection was carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. Infection control processes were 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 were 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>Restraint and enabler used are the least restrictive options in order to ensure resident safety and independence, sighted consents for restraints and enabler use. Restraint and enabler use is assessed, interventions recorded, monitored, included in the PCCP's, risks identified, monitoring timeframes identified, evaluations are timely and appropriate and restraints and enablers are reflected in the person centred care plans.</p> <p>The restraint register reflects restraints and enabler being used in the service. Restraint competencies were current for all staff, sighted the competency register.</p>
<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 service had processes for determining restraint approval, sighted all the restraint consent records. Staff members interviewed and residents' files reviewed for restraint management evidenced clearly identified and recorded responsibilities. Residents' files sampled evidenced input into the restraint approval processes from resident's and family members.</p> <p>The service had opportunity to feedback on restraint management processes at monthly quality meetings, confirmed during interviews. The restraint committee, including the general practitioner were responsible for the restraint approval review process. The role of the restraint coordinator (RC) was the responsibility of a registered nurse who is suitably experienced and qualified.</p> <p>Clinical staff members were aware of the restraint co-ordinator's responsibilities, confirmed during interview of health care assistants (HCA's). Orientation and induction programmes for new staff members include an overview of the restraint minimisation and safe practice (RMSP) policies and procedures.</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>Systems were in place to ensure assessment of residents was undertaken prior to restraint usage being implemented, sighted restraint assessments for residents. Residents' files reviewed for restraint management demonstrated restraint assessment and processes were being followed. Residents' files sampled, where restraint was utilised, evidenced restraint assessment risks were consistently documented and the restraints evaluations were completed three monthly or when the resident's needs changed. This included resident and/or family input. Restraint monitoring timeframes were consistently reflected in the person centred care plans. Multidisciplinary reviews evidenced restraint assessment risks were reviewed and the GP signed each restraint form, sighted.</p>
<p>Standard 2.2.3: Safe Restraint</p>	<p>FA</p>	<p>The service has systems in place to ensure restraint is used safely. Restraint policies and procedures</p>

<p>Use</p> <p>Services use restraint safely</p>		<p>identify risk processes to be followed when a resident is being restrained. The monthly reports to the support office included data on restraint use. Residents' files sampled evidenced evaluations/review of restraint goals and interventions.</p> <p>Residents' files reviewed for restraint demonstrated appropriate alternative interventions were implemented and de-escalation was attempted prior to initiating restraint. Residents' files confirmed the reasons for initiating restraint, alternative interventions attempted or considered prior to the use of restraint and advocacy/support services offered. The restraint register recorded information to provide an auditable record of restraint use. The service consistently recorded the restraint risks and monitoring timeframes for all residents using restraints.</p> <p>Staff education in challenging behaviour and restraint minimisation occurred.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The facility's restraint evaluation processes are documented in the restraint minimisation and safe practice policy (RMSP). Residents' files reviewed for restraint evidenced that each episode of restraint was being evaluated and based on the type of restraint being used.</p> <p>Policies guide the service in relation to strategies to minimise use of restraint and management of challenging behaviour. Evaluations of restraint included (a) to (k) as required in this Standard. Residents' files reviewed for restraint practices demonstrated residents' person centred care plan evaluations and multidisciplinary meetings were current. The resident's lifestyle care plans reflected their restraint use.</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>Restraint monitoring and quality review occurred three monthly, as evidenced in the resident files reviewed for restraint management processes. Restraint reviews were documented and reported on to support office at Oceania as part of the quality indicators.</p> <p>Restraints are discussed at the monthly registered nurses and staff meetings. The RMSP policies and procedures include monitoring and quality review processes. The quality committee meeting minutes were sighted.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

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End of the report.