

# Rosewood Resthome Limited

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## Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Rosewood Resthome Limited
<b>Premises audited:</b>	Rosewood Resthome and Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 12 March 2015 End date: 12 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>	61

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Rosewood Resthome and Hospital in Christchurch is a 64 bed rest home and hospital facility that specialises in care for people with dementia. Occupancy on the day of this surveillance audit is 61. The clinical nurse manager and the facility manager support each other in the day to day management of the facility, with the general manager providing operational oversight.

All units in the facility were visited as part of the audit process. This included sampling files, interviewing family, residents and staff and observing the environment. The service continues to provide a level of care and support that the residents and family members are satisfied with. Staff are trained to the required levels to provide care for people requiring rest home and hospital dementia level care, and staffing levels are within recommended levels to provide the supervision required.

An area of continuous improvement was identified regarding care plans.

All six previous required improvements have been addressed and one new area requiring improvement has been identified; this relates to staff identification.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Open disclosure is occurring and there are procedures in place to ensure that people with special communication needs have these met.

Staff do not wear any form of identification to allow residents and their family to know the name of those involved in their care and this requires improvement.

A complaints policy guides the complaints process and includes management of the complaints register. Complaints are being investigated and resolutions are documented.

## 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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A mission statement, philosophy and quality and risk management plan are in place and all have been recently reviewed.

There is evidence that the clinical nurse manager and the facility manager both have the relevant expertise to manage their roles and provide relief when the other is on leave. The general manager has extensive management experience and has attended relevant management courses to meet service agreement requirements.

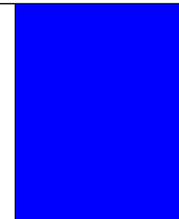
Organisational policies and procedures are controlled documents that are reviewed every two years and guide safe practices and requirements within the facility.

Accidents and incidents are being reported and reviewed and an internal audit process is being maintained to ensure the required standards are being upheld. There is now evidence that new admission injuries are being reported meeting a previous area requiring improvement. The analysis and review of quality improvement data occurs monthly and is reported at quality and staff meetings.

An orientation programme is in place for all new staff. Annual appraisals are being undertaken and medication training is held annually which addresses a previous required improvement. Other relevant training is occurring as per contractual requirements.

Rosters in both areas indicate staffing levels are safe and that there is registered nurse cover for 24 hours a day on seven days of the week.

## 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.		All standards applicable to this service fully attained with some standards exceeded.
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The interRAI electronic programme is being used for individualised assessments and reassessments of residents' needs. Additional specific assessments for challenging behaviour and falls risk are available. Assessments contribute to the identification of risks and the development of personalised goals, all of which have associated interventions. A previously identified shortcoming related to assessments for challenging behaviour, nutrition and pain is no longer evident. The care plans in place were comprehensive.

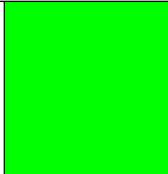
Activity plans, which staff can use over a twenty four hour period, were in place for each resident whose file was reviewed. These complement the organisational activity schedules in the respective area of the facility. The activity schedules demonstrate diversity and include community integration.

Evaluations and reviews were being consistently completed; demonstrate accuracy and showed personal goals were being revisited in a timely manner. The systems used for evaluation processes have been reviewed over several years and demonstrate continuous improvement.

A full review of medicine management has been undertaken and the previously identified prescription and competency issues of concern were not evident. Medicine management systems of storage, documentation, administration and policies and procedures meet legislative requirements and required guidelines.

The food service and kitchen services have also had a full internal review and a quality improvement programme implemented. The four weekly rotational menu has been reviewed by a dietitian. Systems in place enable any special dietary requirements and personal preferences to be accommodated. Food is available over 24 hours. Food safety systems, including storage, were being monitored and recommended guidelines followed.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility has a current building warrant of fitness and there has not been any additional building, or modifications of buildings, since the last audit. A previous issue requiring improvement relating to testing of medical equipment has been addressed.

## Restraint minimisation and safe practice

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

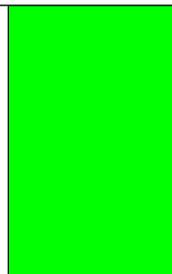


Standards applicable to this service fully attained.

Restraint minimisation policies and procedures meet the requirements of the standard and guide practice. There are currently three residents using restraints. Options, such as sensor mats and lowering the bed, are considered first. Assessment, consent, intervention and review processes are well documented for each person who has a restraint.

## 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.

Surveillance of infections is occurring. The clinical nurse manager and the facility manager ensure the programme is implemented and collate and analyse infection control data. Quality and staff meetings confirm that conclusions and recommendations to reduce infections are being reported and implemented.

## 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>	1	15	0	1	0	0	0
<b>Criteria</b>	1	38	0	1	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>A documented policy guides management of the complaints process in accordance with Right 10 of the Code of Health and Disability Services Consumers' Rights. A complaint register records any formal complaints, the last of which was recorded in December 2013. Interviews with the facility manager (FM) and general manager (GM) confirmed how they manage complaints and this was reflective of the facility's policy.</p> <p>Staff interviewed confirmed any concerns raised by residents or family members were raised in the first instance with the clinical nurse manager (CNM), however they verified that there have been no such complaints in the past few years. Open communication between the facility and family was confirmed at resident and family interviews during the audit and how this helps address any emerging problems.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	PA Low	<p>Open disclosure was evidenced in residents' records, including a contact log with families having been notified of any untoward events. The procedures are guided by an organisational policy. Residents interviewed reported they were kept informed.</p> <p>Alternative means of communication for residents can be accommodated, including support for management of hearing and visual aids. Care staff or registered nurses do not wear name badges making it difficult for residents to identify those involved in their care and this requires improvement.</p> <p>No occasions have arisen since the previous audit in which interpreter services have been required, although there</p>

<p>environment conducive to effective communication.</p>		<p>are processes in place should this be required.</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>The organisation has undertaken a review of its values and mission, with input from staff, and this was signed off by the GM in 2014. The philosophy of care reflects the organisational mission and values, and is sighted at the entrance to the facility. A business plan for 2014 to 2015 has been developed and implemented, with input from the owner, GM, FM and CNM. It includes an analysis of the organisation's eight goals, and during interview the GM, FM and CNM were able to demonstrate how the philosophy is imbedded in the organisation. The operational plan is fully documented, and includes working relationships, formal and informal processes instigated by the management team to ensure evidence is provided in planning and progress in activating the business plan.</p> <p>The FM has a background in nursing and management and is transitioning into the FM role with the support of the GM. The CNM is a registered nurse supported by the FM in the day to day running of the facility. All three managers have undertaken additional training in relation to management in the past two years.</p> <p>Documentation reviewed for the FM and CNM confirmed their suitability for the role.</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 principles.</p>	<p>FA</p>	<p>There is sighted a detailed organisational quality and risk management system. Quality objectives, quality strategy, the role of the quality committee, internal audit and corrective actions processes are clearly defined.</p> <p>Clinical indicators, staff education and resident centred care measures are described and evaluated. Quality meetings are documented with outcomes identified for follow-up. The quality meeting minutes reviewed included discussion about clinical indicators, infection control and restraint as set agenda items. The quality meeting has representation from key areas, such as management, housekeeping, kitchen services and care delivery.</p> <p>The risk management review is formalised within this meeting structure and all the risks are reviewed to reflect the level of risk or changes in the nature of the risk.</p> <p>A full suite of clinical and management documents were in place in the facility, with one paper copy in circulation at the facility. Documents are scheduled to be reviewed annually, or two yearly according to type. Those reviewed met these timeframes, were current, and there were no discrepancies between documents and indexes within the document control system.</p> <p>Processes are in place to measure quality indicators. This include accident, incidents (such as, resident falls, infection surveillance, use of restraints and enablers), internal audits in key areas, completion of staff performance appraisals and training evaluation.</p> <p>Corrective action processes have been applied where audit results did not reach the required standard. These have been closed out when achievement has been met.</p>

		<p>Results of audits are presented at the quality and staff meeting and this was supported by graphs and diagrams where appropriate.</p> <p>Data analysis is occurring and being reported, with the level of detail, analysis and evaluation required.</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>	FA	<p>The FM interview demonstrated an awareness of essential notification reporting and obligations. She was able to describe reporting requirements and circumstances, such as notifiable infections, health professional competency issues and critical incidents which should be reported.</p> <p>A range of incidents and accidents reports were reviewed at audit dating to February 2015. This included separate categories and records for staff incidents. This demonstrated a culture of reporting of staff and resident related incidents. Findings show the facility currently has a 90% no fall rate. There is evidence of reporting all new admission injuries addressing a previous area requiring improvement.</p> <p>Interviews with five staff confirmed their understanding of reporting requirements and the completion of incident reports.</p> <p>Discussion relating to incidents and other adverse event data is evident in all meetings; staff, RN, quality and residents. There was detail in the minutes to reflect discussion of possible prevention strategies to maintain a very low falls rate.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Health professionals operating under the Health Practitioners' Competency Assurance Act 2003 have annual practising certificates on file. All those sighted were current.</p> <p>Personnel files have been reviewed and on-going education, competencies and appraisals are recorded. An electronic record was also sighted that matched the hardcopy notes. A short appraisal at the completion of the orientation period was implemented. Records of work visas were maintained and included in individual staff files.</p> <p>There was evidence of processes for police vetting and reference checking prior to employment for new staff.</p> <p>There is evidence in staff files reviewed that staff appraisals are now occurring annually, addressing a prior required improvement. Staff interviewed confirmed appraisals are an opportunity to identify on-going training needs and that on-going education within the facility is regular and relevant and meets their needs.</p> <p>A structured orientation programme is used for new staff with generic and specific requirements according to the staff group. Competencies in core skills were defined, with an orientation checklist signed and dated on completion of each step. Staff interviewed reported that a detailed and supervised induction programme was in place.</p> <p>Core competencies required as part of the dementia service agreement standard is mandatory for all new care staff,</p>

		<p>and documented evidence showed this has been completed within the required timeframes. Fire and first aid training is also mandatory and offered at least annually.</p> <p>Staff interviewed confirm if they do not attend mandatory training they have a letter sent to them requesting an interview to discuss the matter.</p> <p>The FM in conjunction with the CNM developed the annual training programme which includes: the Code of Rights and advocacy; health and safety; clinical care; abuse and neglect reporting and prevention; infection control; fire and evacuation; chemical safety and awareness; cultural safety; dementia and challenging behaviours; and medication management, meeting a previous area of required improvement.</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>Safe staffing levels are described in an organisational policy, are reflective of the roster reviewed and meet contractual requirements. The FM described the processes used to manage risks around staff absences.</p> <p>The facility has two units that are rostered separately and both rosters. Staffing levels and skill mix were in accordance with policy. Any roster gaps were routinely covered.</p> <p>In reviewing the roster over a seven day period it was noted that safe staffing levels were in place, with a mix of eight-hour and shorter shifts. The hospital unit of the facility was staffed by a registered nurse on every shift. Two care staff in each unit and a registered nurse were rostered for night shift across the facility.</p> <p>A full time CNM and the FM supports the care team. A trained diversional therapist (DT) oversees the activities programme five days per week.</p> <p>Care staff and residents' families interviewed reported there were sufficient staff to meet residents' needs over the 24-hour period.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	FA	<p>Organisational policies and procedures include a set for medicine management and an internal audit undertaken within the last eight weeks had good results. Medicines were stored safely. The GPs in both the rest home and psychogeriatric areas were ensuring medicine record charts were being completed according to requirements. This included the documentation of indications for use of pro re nata (as required) medicines, which was raised as an area for improvement at the last audit. Pharmacy checks were being signed off each week and pharmacists reportedly remove unused medicines from the facility. Medicine reconciliation is being done for all new residents, for those returning from an absence, as well as when the medicines arrived from the pharmacy each month. These were consistently recorded and signed. The storage and management of controlled medicines met expectations with pharmacy signing new stock in, weekly counts being done, individual records being maintained and storage system meeting requirements.</p> <p>All staff who administer medicines had a current medicine administration competency, which they renew annually.</p>

guidelines.		<p>This has addressed a corrective action raised at the certification audit when this was not evident. There were no residents in this facility who self-administer their medicines.</p> <p>Administration records of medicines also met requirements. All eleven residents' medicine records reviewed showed all administrations were signed and sample signatures were on file. A mid-day medicine round was observed in the psychogeriatric area and attention to detail, such as hand washing between administrations, re-checking before crushing medicines and observing that medicines had been swallowed, was evident.</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>	FA	<p>Meals are cooked on site according to a four week rotating menu that has winter and summer options. It was reviewed by a dietitian in February 2014. A wide reaching internal audit of meals and kitchen processes and services was undertaken by the management team several weeks prior to the surveillance visit. As a result, a quality improvement project has been implemented to ensure all requirements of the standard are met in a consistent manner. There was evidence that kitchen activities are currently being closely monitored.</p> <p>A registered nurse completes a dietary profile for any new resident and this information is used to ensure residents receive meals according to their individual dietary requirements and personal preferences. Residents are weighed monthly and any significant change is followed up with GP and/or dietetic referral. Independence with feeding is encouraged and finger food is provided to support this; however assistance was observed to occur for those unable to feed themselves.</p> <p>There was vigilance about safe food storage with evidence of stock rotation, leftovers being dated and consumed or discarded within 24 hours, temperatures of fridges and a freezer and of hot food were monitored and food was stored off the floor. Monitoring of the cleaning in kitchen areas was occurring and safe food handling training for kitchen workers was being updated. Food waste is disposed of through usual household waste systems.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The previous certification audit had identified that not all residents' files had assessments of challenging behaviours on admission. Behaviour assessments were not included in all evaluations and there had been a lack of routine assessments of nutrition needs and pain levels.</p> <p>All of the previously identified shortcomings had been addressed in the seven residents' files that were reviewed. The residents' files had behaviour, nutrition and pain assessments on file with updates on them at the three monthly reviews and the full six monthly evaluations. Two registered nurses confirmed that these are now routine processes.</p>
Standard 1.3.6: Service	FA	Caregivers stated they provide services according to the information in the care plans and from what they are told at handovers from the registered nurses at the beginning of each shift. Progress notes are recorded at the end of

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>every shift for each person. These were goal centred and concise, especially in the rest home area. Family members and the residents spoken with were positive about the services provided. Evidence in residents' notes and from observations made on the day of audit showed that services are adequate and appropriate.</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 diversional therapist for the rest home area was interviewed and explained the activity related planning and documentation. All client files reviewed in both sections of the facility have completed resident profile/cultural assessments in them. These contributed to well-documented and individualised diversional therapy/activities care plans, which had personalised goals in them. They were not time-framed as they inform staff of options over twenty four hours. An activities attendance register is filled in daily for each resident, and as each person's evaluation falls due, recently introduced activities progress and evaluation forms are being completed. These replace older versions of these records and showed that weekly updates were being done, reviews were occurring three monthly and wider evaluations being documented six monthly.</p> <p>An activities programme for the month was enlarged, illustrated and colourful. This included a wide variety of options. The service has access to a van for outings and over recent months there has been an increased focus on getting residents out into the community shopping malls and coffee shops, for example. Family members interviewed were satisfied that overall the residents are given multiple options for activities, although motivation of some residents is low and one on one activities, rather than group activities, tended to be more successful.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>CI</p>	<p>Ongoing evaluations and reviews are occurring of the personalised goals in residents' care plans. These are undertaken for all aspects of care including short and long term care plans and for activities plans. Examples include progress notes against personal goals, formal three monthly reviews and six monthly individual multidisciplinary evaluation case conferences. Each review and evaluation is fully documented. Family members confirmed they are involved.</p> <p>Changes were being made to care plan interventions and personal goals as required at each step of the evaluation and review processes. The systems and forms that underpin the evaluation of service delivery and activities plans have been reviewed and modified over several years. Overall, the comprehensive review and evaluation processes of residents' service delivery plans were occurring at a level of continuous improvement.</p>
<p>Standard 1.4.2:</p>	<p>FA</p>	<p>Rosewood Resthome and Hospital has a current Building Warrant of Fitness displayed. It is valid until 1 April 2015.</p>

<p>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>No additional buildings or alterations requiring building consents have been undertaken since it was issued.</p> <p>Medical equipment calibration was reviewed and a sample of devices verified medical equipment was last calibrated in August 2014 meeting a previous area of required improvement.</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>A form sighted for the purpose of collecting monthly data on all infections is maintained by the CNM. The CNM reported that she collects the monthly report sheets and the information is provided to the FM who transfers it to a data analysis sheet and a graph is developed. The reports listed specific infections; urinary tract, eye, respiratory tract, skin and wound and gastro-enteritis infections. The collation was detailed and included up to date analyses of trends and patterns.</p> <p>Documentation sighted included the collection, collation and analysis of information on infections and the measurement of incidence and recommendations for minimising infections. Staff interviewed demonstrated awareness of IC practices and reporting processes.</p> <p>Evidence in the last two quality meeting minutes and staff meeting minutes reviewed verify that infection control surveillance, analyses, conclusions and specific recommendations to minimise reduction in infection have been documented and reported to the organisation.</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>Policies and procedures on restraint minimisation and safe practice outline the requirements of the standard and describe both restraint and enabler use. Observation and staff interviews confirmed that enablers were not in use. There have been three episodes of restraint recorded in the facility since the previous audit. This was verified in the restraint register sighted, which detailed three residents who require lap belts for safety in wheelchairs. The lap belt for the wheelchair was observed to be detached at the time sighted and according to the requirement in documentation. Documentation indicates restraint use was reviewed every month through the quality committee.</p> <p>Restraint use is minimised through staff awareness and training to recognise and address challenging behaviours. The restraint coordinator interviewed is the facility manager and is responsible for maintaining the register of restraint and enabler use, the monthly review of restraint and providing a report on restraint use to the quality committee. Alternatives to restraint are trialled, such as the use of sensor mats and low beds. There are no enablers in use at the facility.</p>



## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	There is evidence that open disclosure occurs within the facility. During the audit it was observed that no clinical (RNs) or care staff wear name badges for identification of those involved in residents' care. The facility manager (FM), clinical nurse manager (CNM) and care staff confirmed this was for safety reasons and that the FM has asked residents' family during meetings for ideas on how to address this. The meeting minutes were sighted verifying this request; however there has been no resolution.	Staff involved in caring for residents do not wear any form of identification to allow residents and their family to know the name of those involved in their care.	Residents are assisted to identify staff involved in their care.  180 days

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress</p>	CI	<p>Review processes in this facility commence with the progress notes for each shift, as they objectively report against the individual’s goals and not just how the resident is. This was especially evident in the rest home area. Three monthly reviews were on file and were up to date in all instances. The six monthly evaluations were resident and goal centred, show the organisation’s full suite of assessments are repeated, demonstrate multidisciplinary involvement in case conferences and include consultation with family members. As noted in standard 1.3.7, similar daily, weekly, three monthly and six monthly review processes are in place for activities plans. Short term care plans and wound care plans were being evaluated every one and two days with the issues being transferred into long term care plans at the next review timeframe when relevant. Ways in which each goal is to be reviewed are documented and facilitate the evaluation processes. Changes were being made to care plan interventions and personal goals as required at each step of the evaluation and review processes.</p>	<p>The comprehensive evaluation and review processes were being undertaken with consistency, accuracy and timeliness. This was evident in progress notes, three monthly reviews and six monthly evaluations in long and short term care plans and in the activities plans. The systems and forms used for the evaluation and review of residents’ care plans have been reviewed by the registered nurses and managers over several years and the change process was described. Overall, the comprehensive review and evaluation processes of residents’ service delivery plans were occurring at a level of continuous improvement.</p>

towards meeting the desired outcome.			
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End of the report.