

# Maniototo Health Services Limited

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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>	Maniototo Health Services Limited
<b>Premises audited:</b>	Maniototo Health Services
<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: 15 April 2015    End date: 16 April 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>	24

# 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

Maniototo Health Services Ltd has an inpatient unit for acute care, a wing for residents requiring hospital level care and a separate building adjacent to the hospital for residents requiring rest home level care.

This certification audit was conducted against the relevant Health and Disability 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 patients, family, management, staff, a general practitioner and a board member.

The general manager provides strategic and operational management with support from the clinical nurse manager. A quality and risk management programme is documented.

Staffing levels were reviewed for anticipated workloads and acuity.

Improvements are required to the following: documentation of consent, the quality programme, signing of staff contracts, and continuity of care through the handover process, risk assessments, medication management and documentation of risks related to the use of restraint.

## 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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Staff demonstrated an understanding of patient rights and obligations and patients indicated they are treated with respect, dignity with regard for privacy and independence. Patients and where appropriate their family are provided with information to assist them to make informed choices.

The patient's/resident cultural, spiritual and individual values and beliefs are assessed on admission.

A complaints process was in place that meets legislative requirements. A complaints register was documented showing evidence of follow up for complaints in a timely manner. Improvements are required to the documentation of consent and documentation confirming that family are informed when incidents have occurred.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The service has a documented quality and risk management system. Policies were reviewed and quality and risk performance is reported through regular meetings.

There are human resources policies implemented. The service has in place an orientation/induction programme that provides new staff with relevant information for safe work practice and there is an ongoing core training programme documented and implemented. Each employee had evidence of recruitment and ongoing performance appraisals.

Improvements are required to the quality programme including review of the strategic/business plan and quality and risk plan, evidence of resolution of issues when identified and analysis of trends to improve quality of service and contracts for staff.

## 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan is utilised as a guide for all staff while the long term care plan is developed over the first three weeks. Care plans reviewed were individualised.

In the files reviewed residents' response to treatment was evaluated and documented and there was evidence that care plans were evaluated six monthly, with relatives notified regarding changes in a resident's health condition.

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

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

Preparation of food services is outsourced with the kitchen staff plating food. Food was presented appropriately with all residents and family stating that the food was excellent. Meals on wheels are served from the kitchen and taken to clients in the community by volunteer drivers.

This certification audit identified improvements are required relating to handover, risk assessments and management of self-administered medicines.

## 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 complied with legislation with a current building warrant of fitness displayed. There is a reactive and preventative maintenance programme including equipment and electrical checks.

The inpatient unit, hospital wing and rest home are appropriate to the needs of patients with lounge areas available. Laundry services are sub contracted apart from facilities that enabled patient/resident laundry to be washed and dried. Staff monitored cleaning to ensure that the facility is cleaned to a high standard.

Essential emergency and security systems were in place with regular fire drills completed. Call bells are in place.

Patients/residents and family stated that there is adequate heating and ventilation.

## 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.		Some standards applicable to this service partially attained and of low risk.
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The restraint minimisation programme defines the use of restraints and enablers. The restraint register was reviewed and was current at the time of the audit.

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

There is an improvement required relating to restraint risk identification.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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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 facility education and training programme. Staff members interviewed were able to explain how to break the chain of infection.

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. The surveillance data is collected monthly and trend expressed in graphs. Appropriate interventions are in place to address the infections. There are adequate hand gels and hand washing facilities for staff, visitors and residents.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	41	0	7	2	0	0
Criteria	0	90	0	8	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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>Maniototo Health Services Ltd (MHSL) has policies in place covering the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>All staff interviewed demonstrated an understanding of the Code. Examples were provided on ways the Code was implemented in everyday practice, including maintaining privacy, giving choices, encouraging independence and ensuring patients could continue to practice their own personal values and beliefs.</p> <p>All patients interviewed reported that they were treated respectfully by staff. This was observed during the audit.</p> <p>Staff had training covering the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers Rights in 2014.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with</p>	PA Low	<p>The service has informed consent policies and procedures in place. Patients and their family are provided with the information they need to make informed choices.</p> <p>Patient files reviewed and patients interviewed verified they were well informed prior to any</p>

<p>the information they need to make informed choices and give informed consent.</p>		<p>procedures being performed.</p> <p>The inpatient and rest home staff interviewed reported that explanations are provided as required supporting informed consent. On admission the patient consent form was completed and signed off by the patient. Informed consent was included and met the requirements for informed consent and patient rights.</p> <p>Informed consent was not documented for treatment in the rest home noting that it is documented in the inpatient and hospital area and all patients had resident agreements in place that were signed by the resident (or family) on entry to the service.</p> <p>Some aspects of informed consent were not evident across all files reviewed including consent for transportation of residents/patients.</p> <p>Advance directives were acknowledged and documentation retained in the individual patient/resident records in the rest home, hospital and inpatient ward.</p>
<p>Standard 1.1.11: Advocacy And Support 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 patients and families. Patient information around advocacy services is available at the entrance to the service and in waiting areas throughout the facility in the form of brochures.</p> <p>Discussion with families and patients identified that the service provides opportunities for the patient and family to be involved in decisions and they are informed about advocacy services.</p> <p>Staff training on the role of advocacy services in 2014 was evident in the training documents. Staff interviewed are aware of the right for advocacy and how to access advocacy services if needed.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Maniototo Health Services Ltd welcomes visitors and has open hours for visiting. The facility is secured in the evenings and visitors could obtain access after hours. Families interviewed confirmed they are welcome to visit and are always made to feel welcome, even outside preferred visiting times. Family were observed to be coming and going freely on the days of the audit.</p> <p>The facility environment was welcoming for children and families and patients stated they felt comfortable and welcome.</p>

<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures was in line with the Code and includes timeframes for responding to a complaint. A complaint's register was in place. The clinical nurse manager manages all complaints, investigations and correspondence with the complainant. All documentation relating to each lodged complaint was held in the complaint's folder and the clinical nurse manager has recently developed a checking system to ensure that complaints were responded to in a timely manner.</p> <p>Information on how to make a complaint is made available at entry to the service, as stated by all patients/residents and their families interviewed. All patients/residents and the families interviewed stated that they know how to go about making a complaint if they needed to and stated they felt comfortable if they wanted to make a complaint. None of the patients/residents or families interviewed had made a complaint.</p> <p>There were no complaints to external agencies since the last audit in the areas audited as part of the certification audit. Two internal complaints were tracked and indicated that these were responded to in the required timeframes.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>All patients/residents and family confirmed that they received information on their rights at entry to the service, including how to make a complaint. Patients and family interviewed confirmed their rights were being upheld by the service.</p> <p>Staff interviewed stated that the Code was discussed with patients and their family on entry and further explanations were provided to support patient understanding.</p> <p>The Code is displayed in poster format in patient waiting areas and in consultation rooms within the facility including the rest home and the inpatient/hospital areas. The Code is also noted to be displayed in Maori. Information regarding the Code and the Health and Disability Advocacy Service was clearly displayed in the foyers of the facilities (i.e. rest home and hospital/inpatient). Code of rights and advocacy information brochures are available and located in information pamphlet holders throughout the facilities.</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</p>	<p>FA</p>	<p>Maniototo Health Services Ltd has policies and procedures that align with the requirements of the Privacy Act and Health Information Privacy Code. Bedrooms have curtains to afford personal privacy if there was more than one bed in the room and all rooms have doors that can be closed when personal cares are being offered. Additional consultation rooms and</p>

<p>for their dignity, privacy, and independence.</p>		<p>outdoor areas are available for private meetings. All patients/residents interviewed stated staff respected their privacy.</p> <p>The service philosophy promotes dignity and respect, which was observed as being demonstrated by staff during the audit.</p> <p>Policies and procedures are in place covering all aspects of monitoring, identifying and acting on abuse and neglect. All staff interviewed demonstrated awareness for monitoring abuse and neglect.</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 has a Maori Health Plan 2014-15 to guide support for Maori in the district. The service has two staff who identify as Maori. A kaumatua and links to the local marae are available to support the service's Maori cultural service implementation along with links to a kuia at the Southern district health board (SDHB). Patient documentation identifies ethnicity and any cultural needs, including identification of the needs of family/whānau. All patients interviewed indicated their cultural needs were recognised and respected.</p> <p>Staff interviewed demonstrated an understanding of the links in place with local Maori kaumatua (Ngatahu) and described encouraging family/whānau to be involved as much as possible.</p> <p>Training around cultural differences and sensitivity was evident in training documents.</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>All staff interviewed were able to describe the process asking patients what their cultural preferences were and all stated that they asked what patients would like in terms of care and treatment. These were identified on admission and recorded in patient files as evidenced in all files reviewed. All patient files recorded ethnicity.</p> <p>All patients/residents interviewed stated that staff discussed individual values and beliefs on entry as part of the Code information provided. All patient files reflected aspects of a patient's cultural, spiritual, values and beliefs. Patients/residents and family interviewed indicated staff were aware of and respected their values and beliefs.</p> <p>The service has policies and procedures in place covering the delivery of culturally safe services that validated patient's individual values and beliefs.</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 service has policies in place, which include providing services reflecting the Code, without discrimination, stigma or exploitation.</p> <p>All staff interviewed were aware of appropriate professional boundaries and were able to demonstrate knowledge to discuss strategies aimed at reducing discrimination.</p> <p>All patients' interviewed indicated staff are non-judgemental and demonstrate good understanding of the Code and provision of services free from discrimination.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>There are policies in place to guide practice. These policies align with the health and disability services. A quality framework is in place, which supports the service's internal audit programme (refer 1.2.3). The service is led by the general manager with medical, nursing leadership and an integrated, multi-disciplinary team environment evident within the organisation. There is access to the general practitioner who is co-located on site, and visiting consultants. In addition resources are accessed through Southern district health board (SDHB) services as required. This was reflected by staff interviewed, documentation in patient files and through meeting minutes reviewed.</p> <p>All staff have access to core training opportunities to ensure they receive information and updates to maintain current clinical practice.</p> <p>All patients/residents and families interviewed expressed a satisfied or high level of satisfaction with the care delivered.</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>PA Low</p>	<p>Patients/residents interviewed stated that they were able to communicate easily with staff and felt free to raise any issues if needed. There was open disclosure and interpreter policies and procedures in place. Families interviewed said they were satisfied with the level of communication they had with the service.</p> <p>All staff interviewed were aware of the need for open and honest communication with patients and their families and were aware of how to access interpreters if required.</p> <p>Accident/incidents, the complaints procedure and the open disclosure procedure informed staff of their responsibility to notify family of any issues or change in condition that occurred, in consultation with the patient. These procedures guide staff on the process to ensure full and frank open disclosure is available. Nineteen incident forms were reviewed in total and incident forms in the inpatient and hospital identified that family had been notified. Some incidents reviewed in the rest home area did not include documentation that family had been</p>

		<p>informed of an incident and progress notes did not necessarily include documentation that family had been informed. Interviews with family members confirmed they were kept informed.</p>
<p><b>Standard 1.2.1: Governance</b> The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>A board provides a governance role with trustees who meet monthly. The board members were elected at the December 2014 meeting with monthly meetings held. The team is identifying governance training for the future and this is recognised as being important given the merger of the two organisations (Cedar Lodge i.e. the rest home and Maniototo Health Services Ltd – MHSL).</p> <p>The service has a clear mission and values documented. The board works with the management team and staff to provide strategic direction and escalation of issues occurred with a monthly report from the general manager (GM) to the board. The board includes trustees with experience in management and financial oversight. The general manager and board chairperson meet informally through the month to ensure that any issues are discussed. There are small groups of board members who meet for specific issues when needed (e.g. around the proposed building).</p> <p>The board appointed the GM who provides operational management and leadership. The board members interviewed stated that the board has confidence in the management team. The GM has accountant and management experience in the rural area and has been in the role for over eight years.</p> <p>There is a strategic/business plan that is developed by the board and general manager. The quality and risk plan is a rolling plan that was reviewed in 2013 with evidence of resolution of corrective actions and risks added as these are identified. There is a quarterly review process for management to update and review the risk/strategy/ improvement plan. The board members interviewed stated that the board was informed of any issues and risks with a risk register reviewed at each meeting.</p> <p>Maniototo Health Services Ltd (MHSL) has a management team that includes the general manager, clinical nurse manager and registered nurse from the rest home. There is medical leadership from the general practitioner who is on site and on call during the week. There is a locum when the general practitioner is on leave to provide medical leadership and also includes the (Primary Response in Medical Emergency) PRIME nurses.</p> <p>There are 31 beds (16 in the Lodge – rest home and 15 dual purpose beds for hospital (long term care) and acute inpatient care. Occupancy on the day of the audit was 24 with one identified as requiring inpatient care, seven requiring hospital care and 15 in the rest home</p>

		area. One resident was identified as requiring respite care.
<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>	FA	<p>The clinical nurse manager has the delegated position of second in charge with the role defined as providing operational management and leadership in the absence of the GM. The general manager stated they had confidence in the clinical nurse manager to manage as the second in charge when required.</p> <p>The clinical nurse manager has experience in management and nursing roles and relevant qualifications including a current practicing certificate. The registered nurse in the rest home is able to provide support with the general manager when the clinical nurse manager is absent.</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>	PA Low	<p>A quality and risk management framework is documented to guide practice.</p> <p>The service has a documented quality and risk management plan that is reviewed by the board at each meeting (refer 2.1.1). Staff identify quality improvement activities and these are discussed at staff and registered nurse meetings.</p> <p>The service has implemented organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. The clinical nurse manager has undertaken a review of policies since their appointment a month prior to the audit. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. All obsolete documentation was stored in a locked secure facility.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections, implementation of an internal audit programme with corrective action plans documented. There was a schedule of audits documented and evidenced that audits are completed in a timely manner. Corrective action plans were documented, however not all show resolution of issues.</p> <p>The service presents data at meetings which included monthly staff and registered nurse meetings. A health and safety meeting and management team meetings have been formed with the first meetings held. The formation of the meetings has focused the service further on quality and risk management. All aspects of the quality programme are discussed at meetings with a set agenda in place. Resident and family meetings have been re-established following the appointment of the clinical nurse manager with the last meeting documented in</p>

		<p>March 2015.</p> <p>There were annual satisfaction surveys reviewed with information fed into meetings.</p> <p>The organisation has a risk management programme that included health and safety policies and procedures, documentation of hazards and documentation of a rolling quality/risk plan that is described as being discussed at board level. An inspection of the site is completed annually.</p> <p>Trends were informally evaluated with evidence of some use of long term data to improve service delivery.</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 GM and board were aware of situations where the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks.</p> <p>Staff are supported through the open disclosure process.</p> <p>Staff received education at orientation on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Ten incident reports in the inpatient and hospital area had a corresponding note in the progress notes and documentation on the incident form to inform staff of the incident with confirmation that these were reported to family in a timely manner. Six of the nine incident forms reviewed in the rest home indicated that these were reported to family (refer 1.1.9) and all were signed off by the registered nurse with actions taken to resolve any incidents. Incidents were discussed at handover as described by staff.</p> <p>Information gathered was regularly shared through meetings including the staff and registered nurse meetings.</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>	PA Moderate	<p>The registered nurses, medical staff, allied health and other health professionals hold current annual practising certificates. In addition, current annual practicing certificates are held on site for midwives who undertake emergency deliveries before transferring out of the facility, typically within four to six hours following delivery.</p> <p>Staff files included appointment documentation and there is an appraisal process in place. All staff are expected to have an annual performance appraisal with all completed in a timely</p>

		<p>manner. Police checks were now completed for staff noting that in the past these were not completed.</p> <p>There was evidence of a completed recruitment process however, contracts were not held on all files.</p> <p>First aid and CPR certificates were held in the staff files along with other training certificates.</p> <p>All staff now completed an orientation programme with this tailored to the area that the staff are working in. There is an annual core training plan. Staff attendance was documented with attendance registers kept for each staff member.</p> <p>Annual medication competencies were completed by staff who administer medicines to patients.</p> <p>Education and training hours exceeded eight hours a year for registered nurses and all other staff relevant to their roles.</p>
<p>Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The staffing policy is the foundation for work force planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of patients. Rosters sighted reflected staffing levels that met patient acuity and bed occupancy. Staff are replaced when on leave as documented in rosters reviewed.</p> <p>The service employs registered nurses with a general practitioner providing clinical oversight of the service. The general practitioner also has a private medical practice on site with locums and PRIME nurses providing cover when the general practitioner is on leave.</p> <p>There are 39 staff providing registered nurse, the management team (general manager, clinical nurse manager and registered nurse rest home), caregivers, allied health staff. Staff in the rest home are predominantly designated to that area with the registered nurse rest home providing 20 hours a week support. There is an activities assistant who works in the rest home and with inpatient and hospital residents.</p> <p>Patients/residents, family members and staff confirm that staffing is adequate to meet the patients' needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p>	<p>FA</p>	<p>The service retained relevant and appropriate information to identify patients and track records. This included information gathered, at admission, with the involvement of the family.</p>

<p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>		<p>There was sufficient detail in resident/patient files to identify resident/patients' on-going care history and activities. Resident/patient files in use were appropriate to the service.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of patient records. Files and relevant patient care and support information could be accessed in a timely manner.</p> <p>Entries are legible, dates and signed by the relevant staff member including designation.</p> <p>Patient files were protected from unauthorised access by being locked away in offices. Individual patient files demonstrated service integration. Medication charts were in a separate folder and this is appropriate to the service.</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>	<p>FA</p>	<p>Residents' entry into the service was facilitated in a competent, equitable, timely, and respectful manner. New residents received admission packs prior to admission. Admission agreements were signed for all residents files reviewed. The facility requires all residents to have Needs Assessment Service Coordinators (NASC) assessments prior to admission, to ensure they are able to meet the resident's needs, sighted.</p> <p>The registered nurses (RNs) admit new residents into the facility, which was confirmed during interview. Evidence of the completed admission records was sighted. The RNs receive hand-over from the transferring agency and utilise this information in creating the appropriate long term care plan 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>	<p>FA</p>	<p>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner.</p> <p>The CM reported that they include copies of the resident's records; including GP visits; medication charts; current long term care plans; upcoming hospital appointments and other medical alerts when a resident is transferred to another health provider.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	<p>PA Moderate</p>	<p>Medicine management policies and procedures were implemented, and included processes for safe and appropriate prescribing, dispensing and administration of medicines. The area was observed to be free from heat, moisture and light, with medicines stored in original dispensed packs and held securely on site.</p>

<p>guidelines.</p>		<p>Medicine charts reviewed 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, allergies recorded and all charts had photo identification. Discontinued medicines were signed and three monthly GP reviews were evident in charts reviewed.</p> <p>All medicines were prescribed by the GPs using pharmacy generated medication administration charts. Medication reconciliation policies and procedures are implemented. Medication fridges were monitored daily. Medication were held securely.. Six monthly reviews and stocktake of the controlled drug register was not evident (see criterion 1.3.12.1). Sharps bins were sighted. Unwanted or expired medications are collected by the pharmacy.</p> <p>Medication administration was observed in the long term hospital and in the acute care services. The staff members checked the identification of the residents, completed cross checks of the medicines against the prescription, administered the medicines and then signed off after the resident took the medicines.</p> <p>Education in medicine management is conducted. Staff are authorised to administer medications. This requires completion of medication competency testing, in theory and practice. All staff members responsible for medicines management have completed annual competencies.</p> <p>Self-administration of medicine policies and procedures are in place and sighted. There were two residents who self-administered their own medication at the time of the audit. Although the RN completed competency assessments for both the residents, the GP did not sign off the assessments. The RN's did not complete checks at each shift to ensure the residents have taken the medicines and the provider did not provide storage for the medicines, that is only accessible to the residents (see criterion 1.3.12.5).</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>Patients were provided with meals that meet their food, fluids and nutritional needs. The registered nurses completed the dietary requirement form on admission and provided information to the contracted supplier and to the kitchen where meals are served. Any patient with special requirements including vegetarian options have these documented both for the contracted supplier of meals and on the white board in the kitchen. These were updated by the registered nurses regularly. The contracted service provided additional or modified foods depending on the need of the residents. This included pureed meals and other options are able to be provided by the kitchen staff e.g. if a resident wished to have soup or salad if they are not feeling well.</p> <p>The supplier has provided the service with a copy of their Dunedin City Council certificate of</p>

		<p>registration/licence (expiry 28 February 2016). A dietician review of the menu was supplied by the supplier – completed in 2014.</p> <p>The contracted provider of meal services also provided meals on wheels which are put into containers and delivered from the service by volunteer drivers. The kitchen staff monitored the fridge and freezer temperatures along with cooked food temperatures as evidenced in the recording. The kitchen staff used clean technique in service of meals for the residents. All prepared foods in the fridge and freezers was covered and dated.</p> <p>Cooked meals were transported to the inpatient and hospital area on a trolley with food covered.</p> <p>The service conducted monthly weighing of residents or more frequent as required as evidence in the weight monitoring folder. Any needs of a resident were passed onto the kitchen staff.</p> <p>The meals were well presented as sighted during the observed lunches.</p> <p>Staff working in the kitchen have completed food handling certificates through the contracted supplier.</p> <p>The menus are on a four weekly rolling basis (summer and winter) and copies are provided to the kitchen from the supplier along with pictures of ways of presenting food. Menus reviewed by the auditors were balanced.</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 the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There was an adequate documented process for the management of declines to entry into the facility. Records of enquiry were maintained and in the event of decline, information was given regarding alternative services and the reason for declining services. Where the service declined a potential resident, the resident, their family, where appropriate and the referrer was informed of the decline. When residents were not suitable for placement at the service, the family and or the resident were 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>PA Low</p>	<p>The resident's needs, support requirements, and preferences are collected and recorded within required timeframes. The RNs or the CM complete a variety of risk assessment tools on admission. Additional assessments were sighted in the resident's file including the medical assessment completed by the GP and recreational assessment completed by the diversional therapist.</p>

		The files reviewed evidenced baseline recordings recorded for weight management and vital signs with monthly monitoring. Staff interviews confirmed that the families were involved in the assessment and review processes. The outcomes of assessments are used in creating an initial care plan, the long term care plan and a recreational plan for each resident however there is an opportunity for improvement relating to risk assessments that were not consistently completed.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long term care plans reviewed were resident focused, integrated, and promoted continuity of service delivery. The initial plan of care is developed on admission while the long term care plans are developed within three weeks of admission. The facility uses an integrated document system where the GP, allied services, the RNs, occupational therapist, physiotherapist and other visiting health providers write their care notes.  The resident files reviewed had sections for the resident's profile, details, observations, long term care plan, monitoring. Risk assessments were not consistently completed (see criterion 1.3.4.2). 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.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Residents received adequate and appropriate services meeting their assessed needs and desired outcomes. Files reviewed recorded interventions for each goal in the long term care plan. Other considerations for example; dietary likes and dislikes, appropriate footwear, walking and hearing aids were included in the long term care plans.  Interview with the GP confirmed clinical interventions were effective and appropriate. Review of files indicated that interventions documented by allied health providers were part of the long term care plans which included; the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist.  Residents and family involvement in the development of goals and review of care plans is encouraged. Multidisciplinary meetings were conducted by the CM to discuss and review long term care plans. All resident files reviewed during the on-site audit were signed by either the resident or by their families.
Standard 1.3.7: Planned Activities	PA Low	The activities programmes reviewed confirmed that independence is encouraged and

<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>choices are offered to residents. The activities coordinator (AC) coordinated the activity programmes and provided different activities addressing the abilities and needs of residents in the hospital and rest home. Activities resource materials were accessible for the staff to utilise. Activities included physical, mental, spiritual and social aspects of life to improve and maintain residents' wellbeing. 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 AC completed a recreation assessment for each resident. The recreation assessments included personal interests, family history, work history and hobbies to ensure resident's participation in the activities. The AC provided the RNs with the recorded assessments to ensure it was included in the long term care plans. Resident files reviewed demonstrated that review of activity plans were not consistently completed every six months. All resident files reviewed during the onsite audit had current activity assessments in place. Residents and family interviews confirmed they enjoyed the variety of activities and were satisfied with the activities programme. Activities included community involvement.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The resident files reviewed showed long term care plans had six monthly reviews completed. Clinical reviews were documented in the multi-disciplinary review (MDR) records, which included input from the GP, RNs, caregivers, OT and other members of the allied health team. Daily progress notes were completed by the caregivers and RNs. Progress notes reflect daily responses to interventions and treatments.</p> <p>Changes to care was documented. Residents are assisted in working towards goals. Short term care plans were developed for acute problems for example: infections; wounds; falls and other short term conditions, however the risk assessments to support these care plans were not consistently completed (see criterion 1.3.4.2). Additional reviews included the three monthly medication reviews by the GP.</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>The CM stated that residents are supported in accessing or in referral to other health and disability providers. The RN's refer residents for further management to the GP; occupational therapist, dietician; physiotherapist; speech language therapist and mental health services.</p> <p>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 is in place. Reporting of incidents occurs 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 these were free from damage.</p> <p>Material safety data sheets were available throughout the facility and these were accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances as part of the infection control training.</p> <p>The provision and availability of protective clothing and equipment is appropriate to the recognized risks associated with the waste or hazardous substance being handled, for example: goggles/visors, gloves, aprons, footwear, and masks. Clothing was provided and used by staff. Protective clothing and equipment was observed as appropriate during a tour of the facility in all required areas. Rooms in the inpatient unit were available for any a patient requiring isolation with appropriate protective equipment and waste management processes able to be put in place.</p> <p>Sluice rooms are accessible.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness was posted in a visible location at the entrance to the facility (expiry date 30 June 2015). There have been no building modifications since the last audit.</p> <p>There was maintenance completed with maintenance requests logged and signed off when completed. While there is not a proactive maintenance schedule, there was active maintenance completed (observed on the days of audit). The service is discussing the location of the services given the need to earthquake proof the inpatient/hospital unit. The general manager has requested an earthquake assessor to establish needs for earthquake proofing.</p> <p>Equipment is available to meet patient needs with a test and tag programme that was up to date. Calibration of medical equipment was completed annually.</p> <p>Interviews with staff confirmed there is adequate and appropriate equipment.</p> <p>There are quiet areas throughout the facility for patient and visitors to meet including a patient/family lounge in both the rest home and the hospital and inpatient areas.</p> <p>There are safe outside areas that are easy for patients and family members to access. The service provides access to public parking facilities that includes disabled parks. Rails and</p>

		<p>ramps are appropriately placed to provide support for patients.</p> <p>There is an ambulance entrance in both the inpatient/hospital area and in the rest home area.</p> <p>The rest home is a separate building located close to the inpatient and hospital area with a covered walkway to the building.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities in the inpatient, hospital and rest home areas. Communal toilets are conveniently located close to communal areas with a system that indicates if it was engaged or vacant.</p> <p>Secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote patient independence.</p> <p>Patients/residents and family members interviewed reported that there are sufficient toilets and showers.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate space provided in all bedrooms to allow patients and staff to move around within the room safely.</p> <p>Equipment was sighted in rooms requiring this with sufficient space for the equipment, patient and staff.</p> <p>There is sufficient room to store mobility aids such as walking frames in the bedroom safely during the day and night if required and mobility scooters are stored and charged appropriately.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has lounge/dining areas in the rest home and inpatient and hospital areas. All areas are easily accessed by patients/residents and staff. Furniture is appropriate to the setting and arranged in a manner which enabled patients to mobilise freely.</p> <p>There are kitchenette facilities in all areas that allow patients/residents and family members to get hot and cold drinks.</p> <p>One room has a kitchenette and outdoor deck area that is usually used for palliative care. The room is large enough to include a dining and lounge area and family can stay if required.</p>

		There are waiting areas in the inpatient area with chairs, pamphlets and magazines available.
<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>	FA	<p>Main laundry services are sub contacted. Washing machines and dryers are available in both the rest home and hospital/inpatient area for completion of personal laundry. Staff complete these tasks.</p> <p>Laundry is collected in coloured covered bags.</p> <p>There were cleaners on site daily. Cleaning was monitored by staff with no issues identified in audits. The organisation was clean on the days of the audit.</p> <p>Chemicals and cleaning cupboards were locked.</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>	FA	<p>An evacuation plan was confirmed as being approved by the New Zealand Fire Service. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill has taken place six-monthly. The orientation programme included fire and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There was always one staff member at least with a first aid certificate on duty – confirmed through review of the roster.</p> <p>All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There were adequate supplies in the event of a civil defence emergency including food, water, blankets and alternative cooking arrangements. There is a resourced kitchen that is stocked with food stuffs to provide residents/patients with food for at least three days.</p> <p>An electronic call bell system is in place with patients confirming that staff were prompt in answering these. There are call bells in all patients' rooms, patients' toilets, and communal areas including the corridors, dining room and lounge areas.</p> <p>The doors are locked in the evening. Systems are in place to ensure the facility is secure and safe for the patients and staff. External lighting is adequate for safety and security. There are security cameras in place covering key outdoor entrances and parking areas. There are pin code locks on outside doors that are not identified as main entrances.</p>

		The sprinkler system was checked monthly by an external contractor. A generator provides power and lighting in the event of an emergency.
<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 patient/resident feedback in relation to heating and ventilation, wherever practicable. Patients 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 patients/residents interviewed confirmed the facilities are maintained at an appropriate temperature with radiators in all areas.</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	The infection control program is maintained and updated by the organisation. The clinical manager was also the infection control coordinator (ICC). 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 of the ICC.
<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 health and safety 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. The management of infections included residents having short term care plans. This was confirmed in resident records sighted.</p> <p>Interview with the infection control coordinator confirmed surveillance was carried out in accordance with the service's infection control policies.</p>
Standard 3.3: Policies and procedures	FA	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

<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>are reviewed annually. This was evident and confirmed during interview with the infection control coordinator.</p> <p>The service has access to micro-biologists at the laboratory and the infection control nurse specialist at the Southern District Health Board (SDHB) 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 hand gels.</p> <p>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 reflected 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 included monthly infection logs and antibiotics use, sighted. Infections were investigated and appropriate plans of action were sighted in meeting minutes. Infection surveillance data was collated and trends were identified by the ICC, sighted records. The surveillance results were discussed in the staff meeting.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has systems in place to ensure restraint use is minimized. The facility used five restraints during the onsite audit days and there was no use of enablers. Staff interviews and records evidenced restraint minimisation and safe practice (RMSP) as well as challenging behaviour training which took place in November 2014. The process of assessment and</p>

		evaluation of restraint use was recorded.
<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>	FA	<p>There are processes for determining restraint approval. Staff members interviewed and residents' files sampled confirmed that responsibilities are clearly identified and recorded. Residents' files sampled showed input into the restraint approval processes from resident's and family members.</p> <p>The service has monthly restraint committee meetings as part of the health and safety meetings. The role of the restraint coordinator (RC) is the responsibility of the clinical manager who is suitably experienced and qualified. Clinical staff members were aware of the restraint coordinator's responsibilities, confirmed during interviews. Orientation and induction programmes for new staff members included 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>	PA Low	<p>Systems are in place to ensure rigorous assessment of residents is undertaken prior to restraint usage being implemented, sighted restraint assessments for three of the five residents who used restraint. Residents' files sampled demonstrated restraint assessment and risk processes were being followed. Residents' files sampled, where restraint is utilised, evidenced restraint assessment were documented and evaluated three monthly or when the resident's needs changed. However the assessments of restraints did not include the identification of restraint risks for the residents (see criterion 2.2.2.1). Resident's files confirmed family input into the restraint processes.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The service has systems in place to ensure restraint is used safely. Restraint policies and procedures identify processes to be followed when a resident is being restrained. The monthly reports to the Trust Board 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 monitoring timeframes for all residents using restraints. Staff</p>

		education in challenging behaviour and restraint minimisation occurred.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<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' long term care plan evaluations and multidisciplinary meetings were current and 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>	FA	Click here to enter text

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.10.4</p> <p>The service is able to demonstrate that written consent is obtained where required.</p>	PA Low	<p>Six of nine files reviewed had informed consent for outings documented and signed. Three of the nine files reviewed had consent for information sharing.</p> <p>Six of the nine files had consent for use of photographs in place.</p>	Not all files included consent for outings, information sharing and use of photographs.	<p>Ensure that consent is documented for treatment, information sharing, transportation e.g. for outings and use of photographs.</p> <p>180 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open</p>	PA Low	Nineteen incident forms in total were reviewed in the rest home, hospital and	Four of the incident forms in the rest home did not include	Ensure that documentation is completed

disclosure from service providers.		<p>inpatient area. Five of the nine incident forms reviewed in the rest home and all incident forms in the inpatient and hospital included documentation that indicated that family were informed in a timely manner of the incident.</p> <p>Interviews with family members including those in the rest home confirmed that they had been informed and this was identified in progress notes.</p>	documentation that family had been notified and progress notes did not evidence this.	<p>confirming that family have been notified in a timely manner after an incident has occurred.</p> <p>180 days</p>
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Data was collected from internal audits, surveys and through reporting mechanisms.</p> <p>There were a range of meetings at all levels in the organisation including head of department meetings and departmental meetings. The quality team has developed a standard agenda to use at meetings.</p>	Trends are not formally analysed.	<p>Review trends with documentation showing outcomes and use to improve services.</p> <p>180 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	There was a schedule of audits, which were completed in a timely manner. Corrective action plans were documented.	Not all corrective actions identified through audits show evidence of resolution of issues.	Ensure that all corrective actions evidence resolution of

		Some corrective actions showed evidence of resolution of issues.		issues.  180 days
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Moderate	Two of seven staff files had a signed contract included in the file. Staff stated that they have signed a contract. All files included a letter of offer.	Five staff files did not include a signed contract.	<p>Ensure that all staff have a signed contract on file.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Medicines management was implemented to manage the safe and appropriate prescribing, dispensing, administration, storage, disposal, and medicine reconciliation however this did not include six monthly reviews of controlled drugs by the pharmacist.	Six monthly reviews and stocktake of the controlled drug register by a pharmacist was not completed.	<p>The pharmacist to complete six monthly stock reviews of controlled drugs.</p> <p>30 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Moderate	The service had two residents who self-administer medicines. The medicines that were self-administered by the residents were an inhaler and Panadol for use when needed. The resident's files were reviewed for competency assessments and sign off by the GP,	The RN's complete competency assessments on the residents who are considered able to self-administer medicines however the GP was not signing off the assessments. Registered nurses were not checking with the	Residents who self-administer medicines to have their competency assessments signed off by the GP, RN's to complete checks to ensure the

		monitoring and documentation of medicines administration and storage of the medicines.	residents who self-administer medicines that they have taken all medicines on each shift and the residents did not have secure storage for their medicines.	residents have taken their medicines on each shift and the residents to have locked storage for their medicines.  30 days
<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	PA Low	Handover records were requested for review to verify continuity of care through the handover process for the residents who had an in-depth review of care completed on their files. Interview with the registered nurses confirmed that handover notes were destroyed after use and therefore not available for RN's on the following shift.	Continuity of care through handover could not be verified.	Continuity of care through handover to be demonstrated in written records.  30 days
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Moderate	Three resident's files had in-depth reviews completed by the auditors. The reviews were of acute problems residents experienced to confirm the level of care for those residents. Although the service identified the resident's needs, for example the need for pain	Risk assessments were not consistently completed to ensure care plans are specific and current.	Risk assessments to be completed to facilitate current care plans.  90 days

		management or the need for a nutritional assessment, the service did not consistently complete risk assessments for the resident relating to these specific needs.		
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	PA Low	Six residents in long term care had their activity plans assessed for six monthly reviews during the onsite audit.	Activity plans reviews were not consistently completed every six months.	<p>All activity plan reviews to be reviewed six monthly or sooner when the condition of the resident changes.</p> <p>180 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p> <p>(f) Maintaining culturally safe practice;</p> <p>(g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer);</p>	PA Low	Restraint processes were reviewed in three of the five resident's files where restraint was being used. The restraint processes included assessments, monitoring and review of restraints.	The restraint assessments did not include the restraint risks.	<p>All restraint assessments to include restraint risks.</p> <p>30 days</p>

(h) Possible alternative intervention/strategies.				
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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.

No data to display
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End of the report.