

Kena Kena Rest Home Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Kena Kena Rest Home Limited

Premises audited: Kena Kena Rest Home

Services audited: Rest home care (excluding dementia care); Residential disability services - Physical

Dates of audit: Start date: 20 May 2015 End date: 21 May 2015

Proposed changes to current services (if any): Please note: the name of the legal entity is Kena Kena Rest Homes Limited. Certificate of Incorporation (WN/830987) 17 October 1996 sighted.

Total beds occupied across all premises included in the audit on the first day of the audit: 38

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Kena Kena Rest Home provides rest home and residential disability level care for up to 41 residents. There were 38 residents during this audit.

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

Residents and family members interviewed were positive about the care provided.

The management team includes two of the three directors; one works as the facility manager and the other as the clinical manager. Service delivery is monitored. There were no areas identified as requiring improvement during this audit.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, was accessible. This information was brought to the attention of residents' (if able) and their families on admission to the facility. Residents and family members interviewed confirmed their rights were met, staff were respectful of their needs and communication was appropriate.

Residents and family interviewed confirmed consent forms are provided. They also confirmed they are given whatever information they require prior to giving informed consent. Residents and family also advised that time is provided if any discussions and explanation are required.

The facility manager is responsible for management of complaints and a complaints register was maintained.

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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Kena Kena Rest Homes Limited is the governing body and is responsible for the service provided at Kena Kena Rest Home. Planning documents reviewed included a business plan, quality and risk management plan, a mission statement, values, and philosophy.

All three of the directors work in the business. One is appointed as the facility manager, one is the clinical manager and the other one is the maintenance manager. Both the managers are registered nurses and are appropriately qualified and experienced. The clinical manager is responsible for oversight of clinical care. Registered nurse cover is provided seven days a week.

There was evidence that quality improvement data has been collected, collated, analysed and reported. There is an internal audit programme in place and internal audits have been completed. Corrective action plans have been developed to address areas identified as requiring improvement. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management. Staff records reviewed provided evidence human resources processes have been followed. Staff education records confirmed in-service education is provided. The validation of current annual practising certificates for health professionals who required them to practice has occurred.

A documented rationale for determining staffing levels and skill mix was reviewed. The minimum number of staff on duty at any one time is two caregivers. The facility manager and clinical manager are available after hours if required. Care staff, residents and family reported there is adequate staff available.

Resident information is entered into a register in an accurate and timely manner.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Entry into the service was facilitated in a competent, timely and respectful manner. The initial care plan has been utilised as a guide for all staff while the person centred care plan was developed over the first three weeks. Care plans were individualised and risk assessments completed. Residents' response to treatment was evaluated and documented. Care plans were evaluated six monthly. Relatives were notified regarding changes in a resident's health condition.

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

Medicine management policies and procedures are documented 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 completed regular and timely medical reviews of residents and medicines. Medication competencies were completed annually for all staff that administered medications.

The facility utilised a four weekly rotating summer and winter menus and have been reviewed by a dietitian. The facility used the services of a chef and a kitchen manager.

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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With the exception of the nine units, all resident bedrooms provide single accommodation and have wash hand basins. The nine units have full ensuite facilities. Residents' rooms were observed to be of varying sizes and adequate personal space is provided in bedrooms. Lounges, dining areas and various other alcoves are available for residents to sit. External areas are available for sitting and shading is provided. An appropriate call bell system is available and security systems are in place. Sluice facilities are provided and protective equipment and clothing was provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site and cleaning and laundry systems included appropriate monitoring systems are in place to evaluate the effectiveness of these services.

The preventative and reactive maintenance programme includes equipment and electrical checks. A current building warrant of fitness is displayed.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint minimisation policy and procedures define the use of restraints and enablers and comply with the standard for restraint minimisation and safe practice. The restraint register was current. Risk assessment, documentation, monitoring, maintaining care, and reviews were identified, recorded and implemented. The resident using restraints had no restraint-related injuries. Staff receive adequate training regarding the management of challenging behaviour and restraint use.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme is reviewed annually for its continuing effectiveness and appropriateness. Staff education in infection prevention and control was conducted according to their education and training programme and recorded in staff files.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	0	101	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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>Staff received education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. All staff have had training on the Code in 2014.</p> <p>Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code was implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents could continue to practice their own personal values and beliefs.</p> <p>The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information.</p> <p>The auditors noted care staff displaying respectful attitudes towards residents and family members.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their</p>	FA	<p>Systems are in place to ensure residents and where appropriate their family are being provided with information to assist them to make informed choices and give informed consent. Written information on informed consent is included in the admission agreements. The clinical</p>

<p>family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>manager and facility manager reported informed consent is discussed and recorded at the time the resident is admitted to the facility. Staff interviewed demonstrated a good understanding of informed consent processes.</p> <p>Residents / family are provided with various consent forms on admission for completion as appropriate and these were reviewed on resident's files. Copies of legal documents such as Enduring Power of Attorney (EPOA) for residents are retained at the facility where residents have named EPOAs and these were reviewed on resident's files, where available.</p> <p>Residents and family interviewed confirmed they have been made aware of and understand the principles of informed consent, and confirmed informed consent information has been provided to them and their choices and decisions are acted on.</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>There are appropriate policies regarding advocacy/support services in place that specify advocacy processes and how to access independent advocates. The facility manager advised independent advocates visit regularly. During these visits the advocates meet with residents and provide education for staff.</p> <p>Care staff interviewed demonstrated an understanding of how residents can access advocacy/support persons. Residents and family interviewed confirmed that advocacy support is available to them if required. They also confirmed this information was included in the information package they received on admission. Observations provided evidence the nationwide advocate details are displayed along with advocacy information brochures. Admission / pre-admission information was reviewed and provided evidence advocacy, complaints and Code of Rights information is included.</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>Visitors' policy and guidelines are available to ensure resident safety and well-being is not compromised by visitors to the service (for example, visitors are required to sign in and out via registers). The activities programme includes access to community groups and there are systems in place to ensure residents remain aware of current affairs.</p> <p>Residents and family members interviewed confirmed they can have access to visitors of their choice, and confirmed they are supported to access services within the community. Access to community support/interest groups is facilitated for residents as appropriate and a van is available to take residents on community visits. Residents are encouraged to be involved in community activities and to maintain family and friends networks.</p> <p>Residents' files reviewed demonstrated that progress notes and the content of care plans</p>

		include regular outings and appointments.
<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>The facility manager is responsible for complaints and there were appropriate systems in place to manage the complaints processes. A complaints register was maintained that included verbal and written complaints and was reviewed during this audit.</p> <p>The facility manager advised there have been no complaint investigations by the Ministry of Health, Health and Disability Commissioner, District Health Board (DHB), Police, Accident Compensation Corporation (ACC) or Coroner since the previous audit at this facility.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and family interviewed demonstrated an understanding and awareness of these processes. Resident meetings are held three monthly and residents are able to raise any issues they have during these meetings. This was confirmed during interview of residents and family and review of resident meeting minutes.</p> <p>Observations provided evidence that the complaint process was readily accessible and/or displayed. Review of quality meeting minutes provided evidence of reporting of complaints to staff. Care staff interviewed confirmed this information is reported to them via the quality and staff meetings.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The Code of Rights and information on the advocacy service were available and displayed at the facility. This information is provided as part of the pre-admission and information packs. The pre-admission and admission information packs were reviewed and contain, but were not limited to, information on the Code, advocacy and complaints processes. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to the resident's admission. Residents and family interviewed confirmed explanations regarding their rights occurred on admission. They also confirmed care staff provided them with information on their rights any time they have had a query.</p> <p>Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</p> <p>Residents interviewed confirmed they had access to an advocate if needed. The facility manager advised that independent advocates visit the facility on a regular basis. Residents'</p>

		meetings were held three monthly and the meeting minutes indicated residents are aware of their rights. The completed resident survey questionnaires indicated residents are aware of their rights and are satisfied with this aspect of service delivery.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents were observed being treated with respect by staff during this audit. This was confirmed during interviews of residents and family members and during review of the completed satisfaction survey questionnaires.</p> <p>Staff receive training on abuse / neglect as part of the compulsory in-service education study sessions. Abuse and neglect education was last provided in March 2014 by an external educator. Education on abuse, sexuality and intimacy and challenging behaviour was also provided in 2014. Privacy education was provided in February 2015.</p> <p>All bedrooms provide single accommodation. Staff were observed knocking before entering residents' rooms and keeping doors closed while attending to residents. Care staff interviewed demonstrated an awareness of residents' rights and the maintenance of professional boundaries.</p> <p>Activities in the community are encouraged and the facility manager advised some of the residents attend community events independently.</p> <p>A chaplain visits and holds church services on site two weekly. A monk also visits the facility monthly and provides spiritual support including meditation.</p> <p>Values, beliefs and cultural aspects of care were recorded in residents' clinical files reviewed.</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>	FA	<p>The organisation has a Māori Health Plan that includes the three principals of the Treaty of Waitangi: Partnership, Participation and Protection. The Māori Health Plan describes the holistic view of Māori health that is to be incorporated into the delivery of services (whanau, Hinengaro, Tinana and Wairau). The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan.</p> <p>There are currently two residents and three staff who identify as Māori. Access to Māori support and advocacy services is available if required from a Kaumatua in the local community. Contact details for other kaumatua and kuia from within the local community is recorded in the Māori Health Plan.</p> <p>A cultural assessment was completed as part of the care plan for all residents. Specific cultural</p>

		<p>needs were identified in the residents' care plans and this was sighted in files reviewed.</p> <p>Staff were aware of the importance of whanau in the delivery of care for the Maori residents. Cultural safety education is provided as part of the in-service education programme. Whanau are able to be involved in the care of their family members.</p> <p>Care staff interviewed demonstrated an understanding of cultural safety in relation to care. They also confirmed that processes are in place to ensure that if there are residents who identify as Māori, that they have access to appropriate services. Cultural safety education is provided as part of the in-service education programme.</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>Documentation provided evidence that appropriate culturally safe practices were implemented and maintained, including respect for residents' cultural and spiritual values and beliefs. Documentation lists the details on how to access appropriate expertise including cultural specialists and interpreters.</p> <p>Residents' files demonstrated that admission documentation identifies the ethnicity, cultural and spiritual requirements for the residents as well as family/whanau contact details. Residents have a cultural assessment completed as part of the care planning process.</p> <p>Residents interviewed confirmed their culture, values and beliefs are being respected, and their spiritual needs are met. These findings are supported during review of the completed questionnaires for the resident survey.</p> <p>During interview care staff demonstrated an understanding of cultural safety in relation to care. Staff also demonstrated processes are in place to ensure residents have access to appropriate services to ensure their cultural and spiritual values and beliefs are respected.</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>Policies and procedures outline the safeguards to protect residents from abuse, including discrimination, coercion, harassment, and exploitation, along with actions to be taken if there is inappropriate or unlawful conduct. Policies and procedures and staff files reviewed included copies of code of conduct that all staff are required to adhere to. These documents also address any conflict of interest issues including the accepting of gifts and personal transactions with residents and are reviewed. Expected staff practice is also outlined in job descriptions and employment contracts, which were reviewed on staff files.</p> <p>The facility manager described the process for managing residents' 'comfort account' funds.</p> <p>A review of the accident/incident reporting system, complaints register and interview of the</p>

		<p>facility manager indicates there have been no allegations made by residents alleging unacceptable behaviour by staff members.</p> <p>Residents and family interviewed reported that staff maintain appropriate professional boundaries. Care staff interviewed demonstrated an awareness of the importance of maintaining boundaries and processes they are required to adhere to.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Systems are in place to ensure staff receive a range of opportunities which promote good practice within the facility. Documentation reviewed provided evidence that policies and procedures are based on evidence-based rationales.</p> <p>Education is provided by specialist educators as part of the in-service education programme which is overseen by the clinical manager. The District Health Board (DHB) and other external agencies also provide education as part of the in-service education programme. The clinical manager and the facility manager described the process for ensuring service provision is based on best practice, including access to education by specialist educators. Staff interviewed confirmed an understanding of professional boundaries and practice.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Open disclosure policy and procedures are in place to ensure staff maintain open, transparent communication with residents and their families. Residents' files reviewed provided evidence that communication with family members was being documented in residents' records.</p> <p>Residents and family interviewed confirmed that staff communicate well with them. This finding was confirmed in the collated results of the resident survey completed in March 2015 and the family survey completed in November 2014. Residents interviewed confirmed that they are aware of the staff that are responsible for their care.</p> <p>The facility manager advised access to interpreter services is available if required via staff, family and the local community if required. They also advised there are currently no residents who require interpreter services.</p> <p>The residents and family are informed of the scope of services and any items they have to pay that is not covered by the agreement. Admission agreements were reviewed and this was clearly communicated in each agreement.</p>
<p>Standard 1.2.1: Governance</p>	FA	<p>Kena Kena Rest Homes Limited is the governing body and is responsible for the service</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>provided at Kena Kena Rest Home. A business plan and a quality and risk management plan were reviewed and included goals and objectives. A mission statement, values, vision and objectives were also reviewed. There was evidence of monitoring and review of the goals in the business plan. The directors hold annual meetings which are also attended by the accountant.</p> <p>The facility is managed by two of the three directors; the third director is the maintenance person. The two managers have owned and managed Kena Kena Rest Home since 1996. One manager/registered nurse is the clinical manager and the other manager/registered nurse is the facility manager. The facility manager (FM) is responsible for the day-to-day management of the facility. The clinical manager (CM) is responsible for oversight of clinical care. The annual practising certificates for the FM and CM were reviewed and are current. There was evidence on the FM's and CM's files of ongoing education.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative or other services involved in referring residents to the service.</p> <p>Kena Kena Rest Home is currently certified to provide 41 rest home and residential disability care beds for residents aged less than 65. There were 35 rest home and three residential disability residents during this audit.</p> <p>The service provider has funding contracts with the District Health Board (DHB) and Ministry of Health to provide aged related residential care (rest home), residential care (non-aged), long term support – chronic health conditions- residential and respite.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the facility manager (FM) and/or the clinical manager (CM) be absent. The CM fills in for the FM if they are absent and the FM for the CM. A registered nurse is available to fill in for the FM and CM if they are both absent at the same time. The CM confirmed their responsibility and authority for this role.</p> <p>Services provided meet the specific needs of the resident groups within the facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects</p>	<p>FA</p>	<p>A quality improvement plan with quality objectives was reviewed. Also reviewed was a quality and risk management plan. Along with the business plan, these are used to guide the quality programme and include goals and objectives. The quality systems, including policies and procedures are embedded at Kena Kena Rest Home.</p> <p>The clinical manager is responsible for oversight of the internal audits and the inservice</p>

<p>continuous quality improvement principles.</p>		<p>education programme. Completed internal audits for 2014 and 2015 were reviewed. Family, resident and staff satisfaction surveys are completed as part of the audit programme and collated results for all three surveys were reviewed.</p> <p>Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk. A health and safety manual was available that included relevant policies and procedures.</p> <p>Two monthly quality meetings are held. Resident and staff meetings are held three monthly. Meeting minutes reviewed provided evidence of reporting / feedback on completion of internal audits and various clinical indicators. Meeting minutes for 2014 and 2015 were reviewed.</p> <p>Clinical indicators and quality improvement data is recorded on various registers and forms and were reviewed as part of this audit. There was documented evidence quality improvement data is being collected, collated, analysed, evaluated and reported. There was evidence this information is being reported to staff via staff meetings.</p> <p>Quality improvement data reviewed, including internal audits and meeting minutes provided evidence that corrective action plans are being developed, implemented, monitored and signed off as being completed.</p> <p>Relevant standards were identified and included in the policies and procedures manuals. Policies and procedures reviewed are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly including a policy for document update reviews and document control policy. Staff confirmed during interviews that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p> <p>A health and safety manual was available. There was a hazard reporting system available as well as a hazard register. Chemical safety data sheets were available that identify the potential risks for each area of service.</p>
<p>Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their</p>	<p>FA</p>	<p>Staff were documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by either the facility manager (FM) or the clinical manager (CM) and signed off when completed. Corrective action plans to address areas requiring improvement were documented on accident/incident forms. One of the two registered nurse managers undertakes assessments of residents following an accident if they are on duty. They are available after hours and are contacted if required. Neurological observations and</p>

<p>family/whānau of choice in an open manner.</p>		<p>falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>There was documented evidence of communication with family and GP on the accident/incident form and in resident progress notes following and adverse event and if there is any change in the resident's condition. Residents and family confirmed this during interviews. There is an open disclosure policy.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Staff also confirmed they are completing accident / incident forms for adverse events. Policy and procedures comply with essential notification reporting (e.g. health and safety, human resources, infection control).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checking, completed orientations and competency assessments (as appropriate). Copies of annual practising certificates were reviewed for all staff that require them to practice and are current.</p> <p>The clinical manager is responsible for the in-service education programme. The education planners for 2014 and 2015 were reviewed and education is provided at least monthly. Individual staff attendance records and attendance records for each education session were reviewed and provided evidence ongoing education was provided. Competency assessment questionnaires were available and completed competencies were reviewed.</p> <p>All care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The clinical manager and facility manager advised that staff were orientated for at least two shifts at the beginning of their orientation. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided.</p>

		Care staff interviewed confirmed they have completed an orientation, including competency assessments (as appropriate).
<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>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurse (RN) cover is provided seven days a week between 7am and 5.30pm. On call after hours registered nurse support and advice is provided by the two registered nurse managers/directors. The minimum amount of staff on duty is during the night and consists of two caregivers.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. There is at least one staff member with a current first aid certificate on each shift. Residents and family interviewed reported staff provide them with adequate care.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident information was entered in an accurate and timely manner into a register on the day of admission. Resident files were integrated and recent test/investigation/assessment information was located in residents' files. Approved abbreviations were listed. Resident files reviewed provided evidence that an entry into the residents' clinical record includes the time of entry and entries are dated.</p> <p>Residents' information was stored in staff areas and was held securely and was not on public display. Clinical notes were current and accessible to all clinical staff. Individual resident files demonstrated service integration. This included medical care interventions. Medication charts were in a separate folder with medication. The resident's national health index (NHI) number, name, date of birth and GP are used as the unique identifier.</p> <p>Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information. Historical records are held securely on site and were accessible.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry into the service was facilitated in a competent, equitable, timely, and respectful manner. Admission packs were provided for families and residents prior to admission and admission agreements were signed. Agreements were kept securely in the administration office.</p> <p>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. The clinical manager (CM) admits new residents into the facility, confirmed during interview.</p>

		Evidence of the completed admission records and nursing assessments were sighted. The CM received hand-over from the transferring agency, for example the hospital and utilises this information in developing the appropriate long term care plan for the resident.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	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. 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.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	<p>Medicine management policies and procedures are in place and implemented, included processes for safe and appropriate prescribing, dispensing and administration of medicines. The area was free from heat, moisture and light, with medicines stored in original dispensed packs, in a locked medicines trolley. Medicine charts were reviewed and listed all medications the resident was taking, including name, dose, frequency and route to be given. Charts were signed by the GP. All entries were dated and allergies recorded. All charts had photo identification. Discontinued medicines were signed and three monthly GP reviews were evident.</p> <p>All medicines were prescribed by the GPs using pharmacy generated medication administration charts. Medication reconciliation policies and procedures were implemented. Medication fridges were monitored regularly. Controlled drugs were kept inside a locked cupboard and the controlled drugs register was current and correct. Sharps bins were sighted. Unwanted or expired medications were collected by the pharmacy.</p> <p>Staff were observed administering medicines safely. Medicine management education and training occurred. Staff who were authorised to administer medications completed medicines management competency testing, in theory and practice. Self-administration of medicine policies and procedures were in place and sighted. There were no residents who self-administered their own medicines.</p>
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	FA	The residents' individual food, fluids and nutritional needs were met. Residents are provided with a well-balanced diet which met their cultural and nutritional requirements. The meals are prepared and cooked on-site by a chef and their team. The menu was reviewed by the dietitian

<p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>on 14 April 2015. The menu review was based on nutritional guidelines for the older people in long-term residential care. A dietary assessment was completed by the RNs on admission. This information was shared with kitchen staff to ensure all needs, food allergies, likes, dislikes and special diets were catered for. The facility provides modified diets e.g. puree diets to meet the dietary needs of the residents.</p> <p>The CM provides the chef with copies of dietary assessments. A white board in the kitchen also contained important reminders about modified diets as well as preferences of residents. The chef interview confirmed documentation of kitchen routines, including the cleaning schedule. Nutrition and safe food management policies defined the requirements for all aspects of food safety. Labels and dates on all containers and records of food temperature monitoring were maintained. The chiller, fridge and freezer temperatures were monitored daily. The chef and the kitchen assistant have current food handling certificates. The kitchen manager is responsible for the implementation of food services. The local district council awarded the service with an 'A' grade for their food safety and hygiene practices.</p> <p>All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</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. The managers/owners assessed the suitability of residents and used an enquiry form with appropriate questions regarding the specific needs and abilities of the resident.</p> <p>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>FA</p>	<p>The resident's needs, support requirements, and preferences were collected and recorded within required timeframes. The CM completes 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 activities coordinator.</p> <p>Baseline recordings were recorded for weight management and vital signs with monthly monitoring. Staff interviews confirmed that the families were involved in the assessment and review processes. The outcomes of the assessments were used in creating an initial care plan, the long term care plan and a recreational plan for each resident.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The long term care plans reviewed were resident focused, integrated, and promoted continuity of service delivery. An initial plan of care was developed on admission while the long term care plans were developed within three weeks of admission. The facility used an integrated document system where the GP, allied services, the CM and FM, activities coordinator and other visiting health providers; for example the nurse specialist and wound care nurse of the capital and coast district health board (C&CDHB), wrote their care notes.</p> <p>The resident files had sections for the resident's profile, details, observations, long term care plans, monitoring and risk assessments. Interventions sighted were consistent with the assessed needs and best practice. Goals were realistic, achievable, clearly documented and included risk ratings from risk assessments. The service recorded intervention for the achievement of the goals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Residents receive adequate and appropriate services meeting their assessed needs and desired outcomes. Interventions were documented for each goal in the long term care plans. Other considerations like pain management, dietary likes and dislikes, appropriate footwear and walking and hearing aids were included in the long term care plans.</p> <p>Interview with the GP confirmed clinical interventions were effective and appropriate. Interventions from allied health providers were included in the long term care plans, this included; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist when needed.</p> <p>Residents and family involvement in the development of goals and review of care plans were 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.</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 activities programmes confirmed that independence was encouraged and choices were offered to residents. The activities coordinator (AC) coordinated the activity programmes. The AC provided different activities addressing the abilities and needs of rest home residents and residents who are younger than 65. 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. During the onsite visit, activities included residents participating in meditation sessions, listening to music and one-on-one activities. Residents and family</p>

		<p>confirmed they were satisfied with the activities programme. Each resident had their own copy of the programme.</p> <p>On admission the AC completes 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 provides the CM with the recorded assessments to ensure it was included in the long term care plans. Review of activity plans was completed every six months, as part of the multi-disciplinary review, or when the condition of the resident changed. All resident files reviewed 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 outings as well as community involvement.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<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, CM, caregivers, AC and other members of the allied health team. Daily progress notes were completed by the caregivers and CM. Progress notes reflected daily response to interventions and treatments.</p> <p>Changes to care was documented. Residents were assisted in working towards goals. Short term care plans were developed for acute problems for example: infections; wounds; falls and other short term conditions. 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>	FA	<p>The CM stated that residents were supported in access or referral to other health and disability providers. The CM referred residents for further management to the GP; dietitian; physiotherapist; speech language therapist, nurse specialists at the C&CDHB and mental health services. 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 nurse specialists.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers</p>	FA	<p>Documented processes are in place for the management of waste and hazardous substances including specifying labelling requirements. Material safety data sheets provided by the chemical representative were available and accessible for staff. Education on chemical safety was provided as part of the staff in-service education programme. Staff interviewed reported</p>

<p>are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>they have received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>Observations provided evidence hazardous substances were correctly labelled, the container was appropriate for the contents including container type, strength and type of lid/opening. Sluice facilities are provided for the disposal of waste. Protective clothing and equipment that is appropriate to the risks associated with the waste or hazardous substances being handled were provided and being used by staff. For example, gloves, aprons, and masks were sighted in the sluice rooms.</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>One of the three directors is the on-site maintenance person. External contractors are used for plumbing, electrical and other specialist areas. There is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Calibration reports for medical equipment were reviewed along with electrical safety tags on electrical items. Documentation and observations evidenced a current Building Warrant of Fitness is displayed that expires 4 June 2015. The facility manager advised a new one is due to be issued.</p> <p>Observations of the facility provided evidence of safe storage of medical equipment. Corridors are narrow in parts and residents were observed to be safely passing each other; safety rails are secure and are appropriately located.</p> <p>Multiple external areas are available for residents and these are maintained to an adequate standard and are appropriate to the residents in Kena Kena Rest Home. Residents are protected from risks associated with being outside including provision of adequate and appropriate seating and shade; and ensuring a safe area is available for recreation or evacuation purposes.</p> <p>Care staff confirmed they have access to appropriate equipment; equipment is checked before use; and they are competent to use the equipment.</p> <p>Residents confirmed they know the processes to follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p>
<p>Standard 1.4.3: Toilet, Shower, And</p>	<p>FA</p>	<p>All bedrooms have wash hand basins. The nine units have full ensuite facilities. There are an adequate number of accessible communal showers, toilets and wash hand basins for</p>

<p>Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>		<p>residents. Toilets and showers are of an appropriate design and number to meet the needs of the residents. The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. Hot water temperatures are monitored monthly and are maintained at a safe temperature.</p> <p>Toilets have appropriate access for residents based on their needs and abilities. Communal toilets and showers have a system that indicates if it is vacant or occupied. Appropriately secured and approved handrails are provided along with other equipment/accessories that are required to promote resident independence.</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>With the exception of the nine units, all bedrooms provide single accommodation. The nine units are large enough to provide accommodation for two people. The facility manager advised these units are only ever shared by couples who want to share. All rooms were personalised to varying degrees. Bedrooms are of various sizes and adequate personal space is provided in bedrooms to allow residents and staff to move around safely.</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>Adequate access is provided to the lounges, sitting areas and dining areas. Residents were observed moving freely within these areas. Residents confirmed there are alternate areas available to them if communal activities are being run in one of these areas and they do not want to participate in them.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Cleaning and laundry policy and procedures are available. There are policies and procedures for the safe storage and use of chemicals / poisons.</p> <p>All linen is washed on site and there is adequate dirty / clean flow. Care staff are responsible for management of laundry. The facility manager described the management of laundry including the transportation, sorting, storage, laundering, and the return of clean laundry to the residents.</p> <p>The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits for laundry and cleaning were reviewed. The cleaner was interviewed and described the cleaning processes.</p> <p>Observations provided evidence that safe and secure storage areas are available and staff have appropriate and adequate access to these areas as required; chemicals were labelled</p>

		<p>and stored safely within these areas; chemical safety data sheets or equivalent were available; appropriate facilities exist for the disposal of soiled water/waste (i.e., sluice), convenient hand washing facilities are available, and hygiene standards are maintained in storage areas.</p> <p>Residents and family interviewed stated they were satisfied with the cleaning and laundry service and this finding was confirmed during review of the satisfaction survey questionnaires.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Documented systems were in place for essential, emergency and security services. Policy and procedures documenting service provider/contractor identification requirements along with policy/procedures for visitor identification were available. Policy/procedures for the safe and appropriate management of unwanted and/or restricted visitors were available.</p> <p>A New Zealand Fire Service letter dated 10 August 2010 was reviewed and confirmed the fire evacuation scheme was originally approved on 13 June 2002. The last trial evacuation was held on 16 December 2014.</p> <p>There is at least one staff member on duty with a current first aid certificate. Emergency and security management education is provided as part of the in-service education programme. Processes are in place to meet the requirements for the 'Major Incident and Health Emergency Plan'.</p> <p>Observations provided evidence that: information in relation to emergency and security situations is readily available/displayed for service providers and residents; emergency equipment is accessible, stored correctly, not expired, and stocked to a level appropriate to the service setting. Observations evidenced emergency lighting, torches, gas for cooking, extra food supplies, emergency water supply (potable/drinkable supply and non-potable/non drinkable supply), blankets, and cell phones.</p> <p>There is a call bell system in place that is used by the resident or staff member to summon assistance if required and is appropriate to the resident group and setting. Call bells are accessible / within reach, and were available in resident areas. Residents confirmed they have a call bell system in place which is accessible and staff respond to it in a timely manner. Sensor mats are used for residents who are high falls risks.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate</p>	<p>FA</p>	<p>Procedures were in place to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents and family interviewed confirmed the facility is maintained at an appropriate temperature.</p>

<p>natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>Observations evidenced that the residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The responsibility for infection control was clearly defined and there were clear lines of accountability for infection control matters in the facility. The FM, who is also a RN, is responsible for infection control. The infection control committee has representatives from the kitchen, cleaning services, laundry, caregivers, the CM and the FM. Monthly meeting minutes were sighted. The FM reported that hand-washing audits were completed several time during the year.</p> <p>There was an infection control programme that was last reviewed in March 2015. Infection control was part of the monthly staff meeting agenda. When a resident presented with an infection, staff sent specimens to the laboratory for sensitivity testing. The GP prescribed antibiotic as per sensitivity, confirmed during interview. The CM created short term care plans and reviewed the effectiveness of the prescribed antibiotics when the treatment was completed. The FM/infection control coordinator (ICC) collated all the surveillance data for benchmarking. Infections were discussed during staff meetings, sighted meeting minutes.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>There were adequate human, physical, and information resources to implement infection control programme and meet the needs of the organisation. Hand washing signs were sighted around the facility to remind staff and residents of the importance of proper hand washing. The facility maintained regular in-service trainings for infection control including standard precautions, personal protective equipment, cleaning, infectious diseases and hand washing. Sighted training records that are aligned with their training planner.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service</p>	<p>FA</p>	<p>Documented policies and procedures for the prevention and control of infection reflected accepted good practice and relevant legislative requirements and were readily available and implemented at the facility. These policies and procedures were practical, safe, and appropriate/suitable for the type of service provided. The policies and procedures sighted complied with relevant legislation and current accepted good practice.</p>

provided.		
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The organisation provided relevant education on infection control to all service providers, support staff, and residents. The infection control education was provided by either by the ICC or external resource speakers. The ICC included hand washing and standard precautions as additional infection control training. Residents interviewed were aware of the importance of hand washing and had access to hand gels.</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>	FA	<p>The ICC was responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) were documented to guide staff. Information was collated on a monthly basis, sighted records for January to April 2015. Surveillance was appropriate for the size and nature of the services provided.</p> <p>Information gathered was clearly documented in the infection log maintained by the ICC. 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. The infection control surveillance register included monthly infection logs and antibiotics use. The organisation had an internal benchmarking system. Infections were investigated and appropriate plans of action were sighted in meeting minutes. 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>	FA	<p>The facility demonstrated that the use of restraint was actively minimised. The service used restraint for one resident, in the form of a lap belt and bedrail. There were no residents using enablers. Interviews confirmed that enabler use is voluntary and the least restrictive option for the residents, when being used. The resident who used restraints had a risk management plan in place. The restraints were documented in their long term care plan of the resident, restraint risks were recorded and the service completed a restraint assessment and consent. There were no restraint related injuries reported. Bedrails had specialised covers when in use, as part of the risk management process.</p> <p>The service had a documented system in place for restraint use, including a current restraint register. Reasons for restraint use were considered and documented in the restraint assessments. The CM was also the restraint coordinator.</p>

<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The facility maintained a process for determining approval of both types of restraints used. The restraint coordinator completed a restraint assessment which was then discussed with the GP prior to commencement of restraint. The restraint approval group is defined in the restraint minimisation and safety policies and procedures.</p> <p>The duration of each restraint and restraint risks were documented in the restraint plans of residents. Caregivers were responsible for monitoring and completing restraint forms when the restraints were in use. Evidence of on-going education regarding restraint and challenging behaviour was evident. Staff members were made aware of the restraint use during monthly staff meetings. This was confirmed during staff interviews.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Restraint assessments included: identification of restraint related risks; underlying causes for behaviour that required restraint; existing advanced directives; past history of restraint use; history of abuse and or trauma the resident may have experienced; culturally safe practices; identification of desired outcomes; and possible alternatives to restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Before resorting to the use of restraint, the restraint coordinator utilised other means to prevent the resident from incurring injury for example the use of sensor mats. Restraint consents were signed by the GP, the resident (when applicable) family and the restraint coordinator. The restraint monitoring forms were completed by the caregivers.</p> <p>Restraints were incorporated in the long term care plan of the resident and reviewed three monthly. The restraint register was up to date. The facility used the restraints safely.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint coordinator evaluated all episodes of restraint. The resident using restraints was evaluated six monthly. Reviews included the effectiveness of the restraint in use, restraint-related injuries and whether the restraint was still required. The resident (if able) and the family were involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the progress notes of the residents regarding restraint related matters. Restraint minimisation and safe practices were reviewed.</p>
<p>Standard 2.2.5: Restraint Monitoring and</p>	FA	<p>The facility demonstrated the monitoring and quality review of their use of restraints. The content of the internal audits included the effectiveness of restraints, staff compliance, safety</p>

<p>Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>		<p>and cultural considerations. Staff knowledge and good practice was also included in their quality reviews. Staff monitored restraint-related adverse events while using restraint.</p>
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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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.