

# FOMHT 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:

**Legal entity:** FOMHT Health Services Limited

**Premises audited:** Jack Inglis Friendship Hospital

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

**Dates of audit:** Start date: 3 June 2015 End date: 4 June 2015

**Proposed changes to current services (if any):** Reconfiguration of services to utilise a storeroom as a two-bed unit with an ensuite, thus increasing bed numbers (dual purpose) from 37 to 39 in the hospital area. HealthCERT has indicated that the impact of this is low risk and Jack Inglis Friendship Hospital (JIFH) has been able to utilise the new facilities since 9 March 2015. HealthCERT has indicated that a partial provisional audit is not required, however TAS has included specific reference to the new facilities during the certification audit as requested by HealthCERT.

**Total beds occupied across all premises included in the audit on the first day of the audit: 76**

# 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

Jack Inglis Friendship Hospital can provide care for up to 77 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. The audit was also to confirm the reconfiguration of services to utilise a storeroom as a two-bed unit with an ensuite, thus increasing bed numbers (dual services) from 37 to 39 in the hospital area.

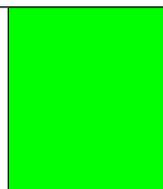
The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

A trust board takes a governance role. The general manager is responsible for the overall management of the facility and is supported by the clinical manager, clinical nurse leader and quality assurance manager. Service delivery is monitored. Staffing levels are reviewed for anticipated workloads and acuity.

An improvement is required to management 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.



Standards applicable to this service fully attained.

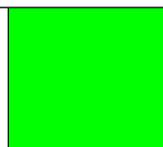
Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service is located close to community facilities and residents can access these as able.

The service has a documented complaints management system implemented. There were no outstanding complaints at the time of audit.

## 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.

The organisation's mission statement and vision have been identified in the strategic plan and are displayed in the facility. Planning covers business strategies for all aspects of service delivery in a coordinated manner to meet residents' needs. The board and the management team regularly review relevant plans and key indicators.

The quality and risk system and processes supports safe service delivery. The quality management system includes an internal audit process, complaints management, resident and relative satisfaction surveys, incident/accident and infection control data analysis. Corrective action planning is implemented with evidence of resolution of issues. Quality and risk management activities and results are shared among staff. Reporting processes include external benchmarking.

There are human resource policies implemented around recruitment, selection, orientation and staff training and development. Staff identified that staffing levels are adequate and interviews with residents and relatives demonstrated that they have adequate access to staff to support residents when needed. Staff are allocated to support residents as per their individual needs.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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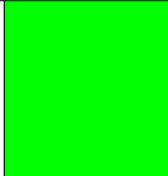
Entry into the service is facilitated in a competent, timely and respectful manner. The initial care plan has been utilised as a guide for all staff while the long term care plan is developed over the first three weeks. Care plans reviewed were individualised and risk assessments completed. Residents' response to treatment was evaluated and documented. Care plans reviewed were evaluated six monthly. Relatives were 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 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 legislation and contractual requirements. Medication charts were reviewed. The general practitioner completed regular and timely medical reviews of residents and medicines. Medication competencies are completed annually for all staff that administer medications.

The facility utilises four weekly rotating summer and winter menus reviewed by a dietitian. The facility uses the services of a chef. The reconfiguration of services to include two more beds and an ensuite to the service will not affect the service' ability to deliver safe and appropriate services.

## Safe and appropriate environment

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

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. There is a secure unit for residents requiring this that has access to a secure courtyard that includes paths, gardens and outdoor areas for leisure.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

The reconfiguration of services to utilise a store room as a two bed unit with an ensuite has been confirmed as part of this audit.

## 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 facility actively minimise restraint use. The restraint minimisation programme defines the use of restraints and enablers. The restraint register is current.

Policies and procedures comply with the standard for restraint minimisation and safe practice. Assessment, documentation, monitoring, maintaining care, and reviews were recorded and implemented, however there is a requirement for improvement relating to the identification of restraint risks. Residents using restraints had no restraint-related injuries. Staff members receive adequate training regarding the management of challenging behaviour and restraint use.

## 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 was conducted according to their education and training programme and recorded in staff files.

Infections are investigated and appropriate antibiotics are prescribed according to sensitivity testing. The surveillance data reviewed was collected monthly for benchmarking. Appropriate interventions are in place to address the infections. There are 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.

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	49	0	1	0	0	0
<b>Criteria</b>	0	100	0	1	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is displayed throughout the facility and new residents and families are provided with copies of the Code as part of the admission process.</p> <p>Staff are provided with annual training around rights and the Code. The clinical staff were observed to implement rights as per the Code in their day-to-day practice.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to the gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that care.</p> <p>All resident files identified that informed consent was collected.</p> <p>Interviews with staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The registered nurse or the clinical manager discusses informed consent processes with residents and their families/whānau during the admission process.</p> <p>The policy and procedure includes guidelines for consent for resuscitation/advance directives. A</p>

		review of files noted that all had appropriately signed advanced directives if the resident was deemed competent to make that decision.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is being acknowledged. Resident information around advocacy services is available at the entrance to the service.</p> <p>Staff training on the role of advocacy services is included in training on The Code with this provided annually to staff.</p> <p>Discussions with family and residents identifies that the service provides opportunities for the family/EPOA to be involved in decisions and they stated that they have been informed about advocacy services.</p> <p>The resident files included information on residents family/whanau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no set visiting hours and family are encouraged to visit at any time. The families reported there are no restrictions to visiting hours.</p> <p>Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. Some residents still attend community activities such as church services and shopping.</p> <p>The facility is close to community facilities and residents report they are encouraged to access these independently as able.</p> <p>Family are encouraged to stay with residents requiring palliative care and a room with kitchen facilities is available when required.</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>	FA	<p>Policy and procedures identify that the organisation is committed to an effective and impartial complaints system. Procedures are in place to show how they support a culture of openness and willingness to learn from incidents and complaints.</p> <p>Complaints management is explained as part of the admission process for residents and family/whānau and is part of the staff orientation programme and ongoing education.</p> <p>Residents and family confirmed that the management's open door policy makes it easy to discuss</p>

		<p>concerns at any time. The complaints register records the complaint, dates and actions taken. There are no outstanding complaints at the time of audit.</p> <p>Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur.</p> <p>There have been two complaints lodged with external authorities since the last audit, however, both have been reviewed as part of an audit against the contract prior to this audit taking place. The complaints were not substantiated and recommendations from the contract audit have been addressed.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>The general manager, clinical manager, clinical nurse leader or a registered nurse discusses the Code, including the complaints process and rights with residents and their family on admission.</p> <p>Discussions relating to the Code are also held at the resident meetings.</p> <p>Residents and family interviews confirmed their rights were being upheld by the service.</p> <p>Information regarding the Health and Disability Advocacy Service is clearly displayed in the foyer of the facility. If necessary, staff could read and explain information to residents as stated by the caregivers and registered nurses interviewed.</p> <p>Information is also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private if this is required.</p> <p>Residents and family members are able to describe their rights and advocacy services particularly in relation to the complaints process.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>The service has a mission statement and philosophy that promotes dignity and respect and quality of life. This includes all residents including those using the dementia unit, hospital or rest home areas. Resident support needs are assessed using a holistic approach. The initial and on-going assessment includes gaining details of people's beliefs and values with care plans completed with the resident and family member (confirmed by residents and family interviewed).</p> <p>Interventions to support these are identified and evaluated.</p> <p>Residents are addressed by their preferred name and this is documented in files reviewed.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage</p>

		<p>any inappropriate behaviour.</p> <p>The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature can be held in the resident's room and there are areas in the facility which could be used for private meetings.</p> <p>Caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas – observed on the days of the audit. Residents and families confirm the residents' privacy is respected.</p> <p>Caregivers interviewed reported that they encouraged the residents' independence by encouraging them to be as active as possible. A physiotherapist is available during the week to help with independence and mobility.</p> <p>Bedrooms are either single with some identified as ones that can be used by couples or residents who wish to share. There are curtains in the rooms that allow residents to be separate.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service implements the Maori Hononga/Relationship Plan June 2012-June 2015 (currently under review) and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs are acknowledged in the Maori health plan. The quality assurance manager provides an annual report to the board that documents progress against the goals identified in the plan.</p> <p>Links to local kaumatua are documented and were described by the management team. One staff member has worked in a marae based service, identifies as Maori and can describe how contacts with kaumatua are made. Links are also identified with the Motueka combined Maori health services and clinically with staff in the Maori palliative care service.</p> <p>There are residents who identify as Maori living at the facility during the audit. There are staff who identify as Maori.</p> <p>Staff reported that specific cultural needs are identified in the residents' care plans and this was sighted in files reviewed.</p> <p>Staff are aware of the importance of whanau in the delivery of care for the Maori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture,</p>	<p>FA</p>	<p>The service identifies each resident's personal needs from the time of admission. This is completed with the resident, family and/or their representative having input into the admission, assessment and</p>

<p>Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>planning processes.</p> <p>There is a culture of choice with the resident determining when cares occur, times for meals, choices in meals and choices in activities. Caregivers are able to give examples of how choices are given to residents who had non-verbal ways of communicating or who required the opportunity to make simple choices. All described the importance of residents having choice regardless of whether they were identified as requiring rest home, hospital or dementia level care.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The staff files have job descriptions and employment agreements that include guidelines regarding professional boundaries. Families and residents report they are satisfied with the care provided. The families expressed no concerns with breaches in professional boundaries, discrimination or harassment.</p> <p>The orientation and employee agreement provided to staff on induction includes standards of conduct.</p> <p>Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>There are policies and procedures to guide practice. These policies align with the health and disability services standards and are reviewed two yearly or as changes occur. A quality and risk management framework supports an internal audit programme. Benchmarking occurs using national data.</p> <p>There is a training programme implemented. Staff described sound practice based on policies and procedures, care plans and information given to them via the registered nurse. The management team is able to describe the use of research to improve services. Specialised training and related competencies are in place for the clinical staff.</p> <p>There are weekly management and monthly quality and clinical meetings attended by managers and staff.</p> <p>Residents and families interviewed expressed a high level of satisfaction with the care delivered.</p> <p>The general practitioner reported a high standard of care provided at the service.</p> <p>Work has been completed to improve the culture of the service, to improve management of falls and to the quality and risk management programme.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure was available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in 15 completed accident/incident forms.</p> <p>Family contact is recorded in residents' files.</p> <p>Interviews with family members confirmed they are kept informed. Family also confirmed that they are invited to the care planning meetings for their family member and could attend the resident and family meetings.</p> <p>Interpreter services are available from the district health board. There are no residents requiring interpreting services.</p> <p>The information pack is available in large print and this could be read to residents.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. All were signed on the day of admission.</p> <p>The admission and welcome pack given to potential and new residents and family includes relevant and individualised information. This includes an information book for those whose loved ones are living with terminal illness if palliative care was being provided and information around dementia care including the philosophy of the service, choice for people in the secure area references to other booklets around dementia care which can be provided by the service to family members.</p> <p>The recent satisfaction survey report indicated that there was satisfaction with the care and support provided.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The service provides dementia, rest home and hospital level of care under the aged care contract. The service is able to provide support for a maximum of 77 residents with 28 beds identified as rest home, 39 as hospital and 10 as providing dementia level of care. There was an occupancy of 76 on the day of the audit (39 residents requiring rest home level of care, 10 requiring dementia care and 27 requiring hospital level of care). This audit has confirmed the reconfiguration of the service to utilise a store room as a two-bed unit with an ensuite with no requirement to change the existing management structure.</p> <p>There is a board that meets monthly. The board has eight members from the community that</p>

		<p>includes expertise around finance and accounting, clinical management and business management.</p> <p>The management team includes the general manager, clinical manager, clinical nurse manager and quality assurance manager. A clinical nurse manager has been recruited but is currently orientating and completing the dementia care course. This clinical manager will take a leadership role in the dementia unit.</p> <p>Communication between the managers takes place on at least a weekly basis.</p> <p>JIFH has a documented vision, mission statement, philosophy and values. These are displayed in the facility and communicated to staff at orientation and through training.</p> <p>The general manager has had six years' experience in aged care with previous experience in accounting, management roles and nursing. The general manager is a registered nurse, has been in the role for 14 months and is supported by other members of the management team. The personnel files of the management team indicate that they have attended education relevant to their roles with each having a performance appraisal completed annually.</p>
<p><b>Standard 1.2.2: Service Management</b></p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>There is a shared second in charge role between the clinical manager (registered nurse) and the quality assurance manager who provide support and oversight in the absence of the general manager. The general manager reported that they have confidence in the abilities of the managers to provide operational including clinical management in their absence. The senior registered nurse acts as the second in charge when the clinical manager is absent.</p> <p>The clinical manager has 12 years' experience in aged care and prior to that has had experience overseas in acute care nursing.</p> <p>The quality assurance manager is a registered nurse with previous experience in community nursing. They have a postgraduate diploma in tamariki ora and in palliative and hospice care.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The strategic plan outlines specific direction for the service. The general manager provides a monthly report to the board on operational progress.</p> <p>JIFH has a documented quality and risk management framework with a quality and risk management plan that is implemented and reviewed. Specific policies relating to quality and risk management are documented.</p> <p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews at least two yearly and as required with all policies current. Policies</p>

		<p>are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy.</p> <p>Service delivery is monitored through review of key performance indicators with a monthly report to the board. The board also receives reports against the Maori hononga health plan. Quality improvement is also identified through review of complaints, incidents and accidents, surveillance of infections, benchmarking data, and implementation of an internal audit programme with corrective action plans documented and evidence of resolution of issues completed. There is documentation that includes collection, collation, and identification of trends and analysis of data.</p> <p>Meeting minutes evidence communication with all staff around all aspects of quality improvement and risk management. There are also two monthly resident and family meetings that keep residents and family informed of any changes. Other meetings are also held such as a monthly falls prevention meeting, a diversional therapy meeting monthly and a restraint/enabler meeting monthly. An infection control meeting is held annually and infection control data discussed at the quality/staff meeting monthly that includes all aspects of the quality and risk management programme. Staff report that they are kept informed of quality improvements.</p> <p>There are annual family and resident satisfaction surveys with satisfaction documented. Any recommendations are considered in light of the results of the survey.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited monthly. The service has received tertiary level ACC accreditation.</p> <p>The service has actively put in place measures to monitor use of equipment including dressing and continence supplies. This has resulted in significant financial gains for the service without compromising safety or wellbeing of residents.</p> <p>There is a service continuity plan in place.</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</p>	<p>FA</p>	<p>Policy identifies that the organisation requires all incidents, accident and adverse events to be reported immediately. Responsibilities are clearly identified.</p> <p>Management understood their obligations in relation to essential notification reporting and knew which regulatory bodies must be notified. An outbreak in March 2015 was reported to appropriate authorities. Staff interviewed stated they report and record all incidents and accidents and that this information was shared at all levels of the organisation, including any follow up actions required.</p>

<p>appropriate their family/whānau of choice in an open manner.</p>		<p>Incident and accident reporting processes are well documented and any corrective actions to be taken are shown on the forms used by the service. Families are notified of any adverse, unplanned or untoward events at times they have nominated. Family interviewed confirmed they are kept well informed of any concerns the staff may have or of any adverse events related to their relatives. Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated and this was observed to have occurred in quality improvement documentation. Falls management strategies are implemented for residents who have falls with an emphasis on this by way of a project to minimise falls.</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>Staff and other health professionals who require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted.</p> <p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Newly appointed staff have police vetting upon employment, references are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff have completed an orientation programme with specific competencies for their roles, which are repeated annually, as confirmed in staff files.</p> <p>Staff undertake training and education related to their appointed roles. Staff education includes an annual training programme and competencies relevant to their role. The education programme covers the contractual requirements of the aging process. There is also education, training and clinical mentoring provided through external providers and the DHB specialists. Education records were sighted in the staff files and the training records. The service also has access to specialist aged care online training. Staff have annual performance appraisals completed. Staff have completed training in dementia care through completion of unit standards.</p> <p>Residents and families interviewed, along with the resident and relatives satisfaction survey results, identified that residents' needs are met by the service.</p> <p>The quality manager retains logs of staff training and completion of competencies. The use of Time Target has allowed the managers to access reports related to completion of training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	<p>FA</p>	<p>Policy identifies staffing levels and skill mix are maintained to meet residents' needs and to comply with the funders contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified staff are on duty to provide safe and quality care. This audit has confirmed the reconfiguration of services to utilise a storeroom as a two-bed unit with an ensuite with no further increase in staffing required.</p>

<p>experienced service providers.</p>		<p>The general manager reports that additional staff would be rostered to meet residents' needs and this was confirmed by staff interviewed. Required staffing levels and skill mix is clearly documented to meet contractual requirements.</p> <p>A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated that all their needs have been met in a timely manner.</p> <p>There is always at least one staff member rostered on to each shift with first aid qualifications.</p> <p>The management team and a senior registered nurse are on call.</p> <p>There are appropriate levels of kitchen, cleaning, activity and maintenance staff.</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>	<p>FA</p>	<p>Information is entered into the resident information management system in an accurate and timely manner. Records are securely stored. Archived records are stored onsite.</p> <p>Progress note entries are made by staff on duty at each shift. The records are legible and the name and designation of the staff member documented on records. All records pertaining to individual residents are integrated. Information of a private or personal nature is maintained in a secure manner and is not publicly 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>	<p>FA</p>	<p>Residents' entry into the service is facilitated in a competent, equitable, timely, and respectful manner. Pre-admission information packs are provided for families and residents prior to admission. Admission agreements were signed for all residents files reviewed, and were kept securely in the administration office. 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 registered nurses (RNs) admit new residents into the facility, confirmed during interview. Evidence of the completed admission records was sighted. The RNs receive hand-over from the transferring agency, for example the hospital 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</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>and coordinated transition, exit, discharge, or transfer from services.</p>		<p>The CNL and 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 guidelines.</p>	<p>FA</p>	<p>Medicine management policies and procedures are in place and implemented, include 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 secure manner. Medicine charts were reviewed. Medicine charts 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 medication administration charts. Medication reconciliation policies and procedures were implemented. Medication fridges were monitored daily. Controlled drugs are 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. Medication administration was observed during lunch time in the hospital. The staff member checked the identification of the residents, completed cross checks of the medicines against the script, administered the medicines and then signed off after the resident took the medicines.</p> <p>Education in medicine management was conducted. Staff were authorised to administer medications. This required completion of medication competency testing, in theory and practice. All staff members responsible for medicines management completed annual competencies. Self-administration of medicine policies and procedures were in place and sighted. There were no residents who self-administered their own medication. Medicines management training occurs for staff. The reconfiguration of services to include two more beds and an ensuite to the service will not affect the service' ability to deliver safe and appropriate medicines management services.</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>The residents' individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet which meets their cultural and nutritional requirements. The meals are prepared and cooked on-site. The menu was reviewed by the dietitian in 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 the CTL or CM 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 RNs, CTL or CM provided the cook or the chef with copies of dietary assessments. A white</p>

		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. Nutrition and safe food management policies defined the requirements for all aspects of food safety. A kitchen cleaning schedule was in place and implemented. Labels and dates on all containers and records of food temperature monitoring were maintained. The chiller, fridge and freezer temperatures were monitored. The chef and the kitchen assistant have current food handling certificates. The reconfiguration of services to include two more beds and an ensuite to the service will not affect the service' ability to deliver safe and appropriate services. All aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.
<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>	FA	<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.</p> <p>The clinical manager (CM) and clinical nurse leader (CNL) assessed the suitability of residents. 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>	FA	<p>The resident's needs, support requirements, and preferences were collected and recorded within required timeframes. The RNs, CNL or the CM completed 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 (DT).</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>	FA	<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 uses an integrated document system where the GP, allied services, the RNs, diversional therapist, activities coordinators, physiotherapist and other visiting health providers write 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 and clearly documented. 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>	FA	<p>Residents received 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 plan; this included; the speech language therapist; the dietitian; needs assessment service coordinators (NASC) and the physiotherapist.</p> <p>Residents and family involvement in the development of goals and review of care plans were encouraged. Multidisciplinary meetings were conducted by the CNL or CM to discuss and review long term care plans. All resident files reviewed 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>	FA	<p>The activities programmes confirmed that independence was encouraged and choices were offered to residents. The diversional therapist (DT) and two activities coordinators (AC's) coordinated the activity programmes. The DT provided different activities addressing the abilities and needs of residents in the hospital, rest home, dementia care and day care, residents under the age of 65 have additional activities to ensure their specific needs, especially social needs, are met. The service had three residents under the age of 65 at the time of the audit.</p> <p>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 going for an outing, music and one-on-one activities. Residents and family confirmed they were satisfied with the activities programme. Each resident had their own copy of the programme.</p> <p>On admission the DT complete 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 DT and AC's completed activity plans for each resident. Reviews of activity plans were completed every six months, as part of the multi-disciplinary review,</p>

		<p>or when the condition of the resident changed. All resident files reviewed during the onsite audit had current activity assessments in place.</p> <p>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. Clinical reviews were documented in the multi-disciplinary review (MDR) records, which included input from the GP, RNs, caregivers, the AC's, DT and other members of the allied health team. Planned activities will not be affected by the reconfiguration of the service.</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, RNs, caregivers, AC's, DT and other members of the allied health team. Daily progress notes were completed by the caregivers and RNs. Progress notes reflected daily response to interventions and treatments.</p> <p>Changes to care were 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 CNL and CM stated that residents were supported in access or referral to other health and disability providers. The RN's referred residents for further management to the GP; dietitian; 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>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents were reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage. Material safety data sheets are available throughout the facility and accessible for staff.</p> <p>Chemicals are stored securely.</p> <p>Personal protective equipment/clothing (PPE) sighted includes disposable gloves, aprons and</p>

		<p>goggles.</p> <p>Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons appropriately.</p> <p>The laundry staff demonstrated knowledge of handling chemicals.</p> <p>The hazard register is current. Staff received training and education to ensure safe and appropriate handling of waste and hazardous substances.</p> <p>During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires in November 2015.</p> <p>Maintenance is undertaken by maintenance staff as required. Electrical safety testing occurs annually and all electrical equipment sighted had an approved testing tag. Clinical equipment is tested and calibrated by an approved provider at least annually.</p> <p>A planned maintenance schedule is in place and indicates that the service is managing and addressing issues before they arise.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is in good condition, bathroom floors are non-slip, the correct use of mobility aids, and walking areas are not cluttered. Regular environmental audits sighted identify that the service actively strives to maintain a safe environment for staff and residents.</p> <p>The service identifies planned annual maintenance and hazard identification forms for areas that require maintenance. There are external areas off the lounge and dining areas. Outdoor areas have shade. There is access to garden areas.</p> <p>Residents and family members confirmed the environment is suitable to meet their needs.</p> <p>The audit approved the reconfiguration of a storeroom as a two-bed unit with an ensuite with these appropriate to meet the needs of residents requiring hospital level of care.</p> <p>The dementia unit is secure and residents have access to a garden area with circular paths for walking.</p>
<p>Standard 1.4.3: Toilet, Shower, And</p>	<p>FA</p>	<p>There are adequate numbers of accessible toilets/bathing facilities located in each wing. Visitor's toilets and communal toilets are conveniently located close to communal areas. Communal toilet</p>

<p><b>Bathing Facilities</b></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>facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Residents and family members interviewed report that there are sufficient toilets and showers.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>All bedrooms are of a size which allows enough space for residents to mobilise with or without assistance in a safe manner.</p> <p>Residents interviewed all spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for equipment (e.g. hoists), at least two staff and the resident.</p> <p>Rooms can be personalized with furnishings, photos and other personal adornments and the service encouraged residents to make the room their own. Residents in the dementia unit are actively encouraged to decorate their room.</p> <p>There was room to store mobility aids such as walking frames in the bedroom safely during the day and night if required.</p> <p>The service has reconfigured a storeroom as a two-bed unit with an ensuite, thus increasing bed numbers (dual services) from 37 to 39 in the hospital area. The rooms are appropriate for residents requiring hospital level of care.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></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 including areas that could be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>Residents could choose to have their meals in their room.</p>
<p><b>Standard 1.4.6: Cleaning And Laundry Services</b></p> <p>Consumers are provided with safe</p>	FA	<p>The service has standing operating procedures in place for cleaning. There is a dedicated secure storage area for cleaning equipment and chemicals. Products are used with training around use of products provided throughout the year. Cleaning is monitored through the internal audit process with</p>

<p>and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>no issues identified in audits.</p> <p>All laundry, including residents' personal laundry, is completed on site. Staff interviewed confirmed they always have enough linen to meet day-to-day needs and there is sufficient stored linen to be used in the event of an emergency.</p> <p>There is a dirty area in the laundry to place the laundry bags and a separate clean area for clothes and linen. The laundry staff were able to describe best practice.</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>Emergency management policies and procedures implemented guide staff actions in the event of an emergency. The emergency plans take into account emergency systems such as fire protection equipment, emergency lighting, and communication. Fire equipment is checked monthly and annually by an approved provider.</p> <p>Emergency supplies and equipment include food and water. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ that can be used for cooking. A generator is available with resources for civil defence kept in a locked area.</p> <p>The emergency evacuation plan and general principles of evacuation are clearly documented in the fire service approved fire evacuation scheme. A letter sighted from the New Zealand Fire Service confirmed the approved evacuation scheme. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service.</p> <p>Emergency education and training for staff includes six monthly trial evacuations. The New Zealand Fire Service attends the fire drills. All staff are required to attend or to have individual training facilitated by the health and safety officer if they cannot attend.</p> <p>Appropriate security systems are in place including sensor lighting at night on the outside of the building. Staff and residents interviewed confirmed they feel safe at all times.</p> <p>Call bells are located in all resident areas. Resident and family/whānau interviews confirmed call bells are answered in an acceptable timeframe. Call bells were randomly checked on the day of the audit and all were displayed and answered in a timely manner.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a</p>

<p>adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>designated external smoking area.</p> <p>Family and residents interviewed confirmed the facilities were maintained at an appropriate 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 infection control committee had representatives in each area of the service management team. This group meets quarterly and infection control matters are discussed at the monthly staff/quality meetings.</p> <p>There was an infection control programme that was last reviewed at the end of January 2015. 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 RN's created short term care plans and reviewed the effectiveness of the prescribed antibiotics when the treatment was completed. 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.</p> <p>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 the 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</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.</p> <p>The policies and procedures sighted complied with relevant legislation and current accepted good practice.</p>

appropriate/suitable for the type of service 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 CM or external resource speakers. The CM included hand washing and standard precautions as additional infection control training. Residents interviewed were aware of the importance of hand washing. Staff members confirmed receiving infection control training and could explain the importance of handwashing in the prevention and control of infection.</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 infection control co-ordinator confirmed a surveillance programme was maintained. Surveillance data was sighted and included infection details related to files sampled. Monthly analysis was completed and reported at monthly general staff meetings.</p> <p>The infection control surveillance is appropriate to the size of the service.</p> <p>The clinical manager (CM) 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. 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 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 coordinator (ICC) collected infection control data and the quality manager (QM) collated all the surveillance data for benchmarking. The service had a non-conclusive infection outbreak in March 2015 which was effectively contained, appropriately managed and resolved within five days.</p> <p>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>
Standard 2.1.1: Restraint	FA	<p>Staff interviewed, observations, and review of documentation demonstrated that the use of restraint was actively minimised. Restraints used in the facility included lap belts and bedrails. There were six</p>

<p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>		<p>residents using restraints and one using an enabler. The files reviewed for restraint and enabler use showed enabler use was voluntary and the least restrictive option for the residents. Residents who used restraints had risk management plans in place. The restraints were documented in their long term care plans. There were no restraint related injuries reported. Bedrails had specialised bedrail covers when in use, as part of the risk management plan.</p> <p>The service had a documented system in place for restraint use, including a current restraint register. Records included assessments, consents, monitoring and evaluation forms, consent forms, authorisation and plans forms. Reasons for restraint use were considered and documented in the restraint assessments. One of the RN's was 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 all types of restraints used. The restraint coordinator completed a restraint assessment which was then discussed with the GP prior to commencement of any restraints. The restraint approval group is defined in the restraint minimisation and safety policies and procedures.</p> <p>The duration of each restraint was 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 residents using restraints 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>	PA Low	<p>Restraint assessments included: opportunity for the identification of restraint related risks; however this was not accurately recorded. The service recorded 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. There is a requirement for improvement relating to restraint risks to be more specifically identified in the restraint assessment records.</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 low beds, mattresses and sensor mats. Restraint consents were signed by the GP, family and the restraint coordinator. The restraint monitoring forms were completed by the caregivers. Restraints were incorporated in the long term care plans and reviewed three monthly. The restraint register was up to date. The GP confirmed that</p>

		the facility used restraint safely.
<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. Long term care plans were evaluated six monthly. Reviews included the effectiveness of the restraint in use, restraint-related injuries and whether the restraint was still required. 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 Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>The facility demonstrated the monitoring and quality review of their use of restraints. Their audit schedule was sighted and included restraint minimisation reviews. The content of the internal audits included the effectiveness of restraints, staff compliance, safety 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>

## 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 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> <p>(h) Possible alternative intervention/strategies.</p>	PA Low	Four of the six files of residents using restraints were reviewed for appropriate restraint processes. All residents had restraint assessments, consents, reviews and monitoring timeframes documented. The assessment forms provide the opportunity for staff to record the restraint risks for each resident. The service recorded over-arching risks but not the specific risks for the specific residents when using certain restraints.	Restraint risks are not specific to the type of restraint used and do not accurately reflect the risks for the resident in relation to their condition and or	Restraint risks to be reflecting the actual risks relating to the condition of the resident and the type of restraint used; for example the risks for a resident who is restless, using a bedrail as restraint are; 'skintears, bruising being tangled up in the bedrails'.

			abilities.	90 days
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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.