# TerraNova Homes & Care Limited - Monte Vista Residential Care

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** TerraNova Homes & Care Limited

**Premises audited:** Monte Vista Residential Care

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

**Dates of audit:** Start date: 20 May 2014 End date: 21 May 2014

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 30

# 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 |
|  | 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

Monte Vista Residential Care provide rest home and hospital level care for up to 41 residents. On the days of audit there were 30 residents. The service is one of five facilities owned and operated by TerraNova Homes and Care Ltd. The company has established systems, policies and procedures for providing a consistent approach to service delivery in all their homes.

This certification audit was conducted against the Health and Disability Services Standards and the provider’s contract with Lakes District Health Board. The audit process included the review of policies and procedures, the review of residents’ and staff files, observations, interviews with residents, families, management, staff and a general practitioner.

The facility manager is appropriately qualified for the position and is very experienced as a manager and nurse working in the aged care sector. Members of the executive management team were onsite for part of this audit and included a health professional who provides ongoing support to clinical coordinators in each facility.

This audit identified one area requiring improvement in the restraint minimisation and safe practice standard. There are two areas rated as continuous improvement resulting in safer and improved services for residents and staff. These are acknowledged in the adverse event reporting system and in staff training and education.

## 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. |

The organisation provides services that reflect current accepted good practice. Consumer rights is explored by new employees as part of their induction and there is regular in-service education for all staff. Families interviewed state that staff often go beyond their expectations in caring for their relatives. They are aware of and have access to information around consumer rights including the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). Information is provided in the information pack, in the main foyer of the service, in residents’ bedrooms and is promoted at regular residents and families meetings.

There was one resident who identified as Maori at the time of audit. The service providers report that there are no known barriers to Maori residents accessing the service. Services are planned to provide and promote individual culture, values and beliefs of the resident. Signed consent forms were sighted in all residents’ files reviewed and obtained from residents’ family/whanau, enduring power of attorney (EPOA) or appointed guardians, as required.

The service has an effectively implemented complaints management process. All stages of the process meet the requirements of the Code of Rights. This process was known by staff, residents and their families interviewed.

## Organisational management

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| --- | --- | --- |
| 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 quality and risk management systems meets the standard and continues to be improved upon. The organisation clearly demonstrated an ethos and commitment to continual quality improvement. Information which monitors the quality and extent of the services being provided is collected, analysed and then reported to the governing body. Where change is needed, planned actions are identified and then acted upon.

All adverse events reviewed were reliably reported and investigated. The service has successfully implemented new approaches to preventing and minimising falls for people who are identified as a high risk. This is an area of continuous improvement.

The manager understands the requirements but has not had to make any essential notifications to the New Zealand Police, the District Health Board or the Ministry of Health since the previous audit.

Human resources are managed well according to policy and good employer practices. New staff have been recruited in ways that ensure their suitability for the position. Orientation to the service and its policies and procedures, including emergency systems, is provided to all new staff. Ongoing staff education is planned and coordinated to ensure that staff receive relevant and timely training on subjects related to older people. Training occurs at least monthly through in-service education sessions, and through self-directed learning and presentations by external experts. Staff competency assessments and performance appraisals are occurring regularly. The service demonstrates continuous improvement in the career pathways it provides for regulated staff and the level of support and engagement with educational achievements for non-regulated staff.

There are sufficient numbers of clinical and auxiliary staff allocated on all shifts, seven days a week to meet the needs of residents who have been assessed as requiring either hospital or rest home level care. Registered nurses (RNs) are on site 24 hours a day seven days a week.

Consumer information management systems meet the required standards. Archived records were being stored securely and all resident information is integrated and readily identifiable using relevant and up to date information.

## Continuum of service delivery

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| --- | --- | --- |
| 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. |

A package which includes pamphlets and booklets provides information and identifies services offered within the facility and as a company. Staff are supported by an action plan for providing information to visitors or potential residents outside of normal working hours and this is included in the policy and process related to entry into the service.

Residents on admission to the service are admitted by a qualified and trained registered nurse who completes an initial assessment and then develops, with the resident and family, a care plan specific to the resident. When there are changes to the resident’s needs a short term plan is developed and integrated into a long term plan reflecting any changes. The service meets the contractual time frames for all short and long term care plans. All care plans are evaluated at least six monthly. All residents have interRAI assessments completed and individualised care plans related to this programme.

Residents are reviewed by their GP on admission and assessed thereafter either monthly or three monthly by their GP depending on their needs. Referrals to the DHB and community health providers are requested in a timely manner and a team approach supports positive links with all involved.

Activity coordinators provide planned activities meeting the needs of residents as individuals and in group settings. Families reported that they are encouraged to participate in the activities of the facility and those of their residents. Residents are encouraged to maintain links with family and the community.

A safe medicine administration system was observed at the time of audit. The service has documented evidence that staff are responsible for medicine management and assessed as competent to do so.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary, likes and dislikes are catered for. The service has a four week, summer/winter rotating menu which is approved by a registered dietitian. The kitchen offers a choice of one of two meals for the main meal served at lunch. Residents and family have access to a hot and cold beverages machine. Resident’s nutritional requirements are met.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |

There is a current building warrant of fitness and all buildings, equipment and chattels are in good condition.

Resident areas (eg, bedrooms and communal living spaces) are safe and appropriate for the people who use them.

Essential emergency equipment and systems are known by staff and are being closely monitored and well maintained.

Cleaning and laundry services meet the requirements. Service delivery is well organised and provided to the satisfaction of residents.

Temperatures in the home were comfortable on the days of audit. There is plenty of electric heating in all communal areas and residents’ bedrooms. Each area has opening doors and windows for maximum ventilation.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| 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. |

Staff are adhering to the company policy and processes for determining safe and appropriate restraint and enabler use. On the days of audit the restraint register is up to date with all the residents who required interventions for safety. The methods used for assessment, consent and approval, monitoring and individual evaluation of residents’ restraint use meet the requirements of this standard.

There is a requirement to amend the policy and implement a regular process for conducting a formal and comprehensive quality review of restraint practice.

## Infection prevention and control

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

The prevention and control policies and procedures reflect current good practice and the service provides an appropriate infection prevention and control management system. The infection control programme supports and implements a reduced risk of infections to staff, residents and visitors. Education is provided to staff on site and staff are also encouraged to attend education provided by other community providers. There is a monthly surveillance programme, where infections information is collated, analysed and trended with previous data. The infection surveillance results are reported at the staff meetings and any required actions implemented as documented in policy and processes. An external contractor benchmarks all data with 15 other facilities.

## 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 | 49 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 2 | 98 | 0 | 1 | 0 | 0 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service Delivery  Consumers receive services in accordance with consumer rights legislation. | FA | The rights policy contains a list of consumer rights that are congruent with the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the code). New residents and families are provided with a copy of the Code on admission and a copy is displayed on the wall in full view for residents, caregivers and visitors and sited in each resident’s bedroom.  On commencement of employment all staff receive induction orientation training regarding residents’ rights and their implementation. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice (as observed at audit). At the time of the audit staff were observed to be respecting the residents’ rights in a manner that was individual to the resident’s needs. Further staff education was planned for June 2015 via a community agency. |
| Standard 1.1.10: Informed Consent  Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | An informed consent policy is in place. Informed consent was evidenced in all care plans and contact with families. Every resident has the choice to receive, refuse and withdraw consent for services. A resident dependent on their level of cognitive ability will decide on their own care and treatment unless they indicate that they want representation.  The residents’ files reviewed had consent forms signed by the residents, and/or family and enduring power of attorney (EPOA). Advanced directives are signed by the resident if competent. Family/whanau interviewed stated that their relatives were able to make informed choices around the care they received and families/whanau were actively encouraged to be involved in their relatives care and decision making. Residents interviewed stated that they were able to make their own choices and felt supported in their decision making. Staff interviewed acknowledged the resident’s right to receive, refuse and withdraw consent for care/services. Staff were able to demonstrate good knowledge around challenging behaviours as evidenced in progress notes, care planning and observed at time of audit. |
| Standard 1.1.11: Advocacy And Support  Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | The advocacy policy documents that all residents receiving care within the organisation’s facilities will have appropriate access to independent advice and support, including access to cultural and spiritual advocate whenever required.  Family/whanau interviewed reported that they were provided with information regarding access to advocacy services at the time of enquiry and at admission and were aware of the location of pamphlets and information situated around the facility. Family/whanau interviewed stated that they were always encouraged to become actively involved as an advocate for their relative and felt comfortable when speaking with staff. |
| 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. | FA | There are no set visiting hours and family/whanau are encouraged to visit. Residents are supported and encouraged to access community services with visitors/family or as part of the planned activities programme. This was evidenced in family/whanau/resident interviews and documented in daily and planned activities in resident’s progress notes and care planning, such as visiting the library or their Marae. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy has a documented complaints process that complies with Right 10 of the Code. At the time of this audit there had been two complaints received since the previous audit. None of these were serious or involved the Office of the Health and Disability Commissioner or the District Health Board. Review of the complaint documentation and interview with the facility manager showed that the complaint procedures were adhered to, investigations occurred and actions happened in a timely manner which resulted in resolution of the complaint. Staff, residents and family demonstrated thorough understanding of the complaint process. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The standard operating procedures identifies that a copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to the resident and family on admission and the admitting staff are to go through the Code with the resident/family on admission.  The family/whanau and residents that were interviewed reported that the Code was explained to them on admission and was also provided as part of the admission pack. The Code of Rights and process was also regularly discussed at family/resident meetings. Family/whanau and residents expressed that they were happy with the care at the facility and provided by the staff. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | A dignity and privacy policy requires the visual privacy and personal space of residents to be respected and observed at all times and that staff will facilitate the use of private space for interaction with visitors and significant others.  The family/whanau members interviewed reported that their relative was treated in a manner that showed regard for the resident’s dignity, privacy and independence. At the time of the audit staff were seen to knock on residents’ doors and await a response before entering. The use of occupied signs on the communal bathroom/toilet doors when in use were noted. The family/whanau interviewed confirmed that they were aware of the different lounges that were available for families and that there were no concerns about privacy. The name of the privacy officer for the facility was sighted on the main notice board in the lounge.  The residents’ files reviewed reflected that residents received services that were specific and individual to their needs, values and beliefs of culture, religion and ethnicity. The family/whanau interviewed reported that staff often go above and beyond families’ expectations when meeting the needs of their relatives.  The family/whanau interviewed expressed no concerns in relation to residents’ abuse or neglect. The family members reported that staff know their relatives well and are very good at intervening prior to and with any potential aggression. This was also evidenced at the time of audit. |
| Standard 1.1.4: Recognition Of Māori Values And Beliefs  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. | FA | The policies acknowledge the organisation’s responsibilities in accordance with the Treaty of Waitangi in meeting the needs of Maori residents. The organisation is committed to identifying the needs of its residents and ensuring that staff are trained and capable of working appropriately with all residents in their care. The individual facilities are responsible for promoting and pursuing consultation, involvement and participation with the local iwi. This was evidenced by knowledge of a local iwi kaumatua who visits, blessings of relatives rooms as required and a Maori Church service that is held once a month at the facility. Local school children have visited and have entertained the residents with kapa haka.  The clinical coordinator/RN and nurse manager/RN reported that there are no barriers to Maori accessing the service. At the time of the audit there were three Maori residents.. The caregivers interviewed demonstrated good understanding of practices that identified the needs of the Maori resident and importance of whanau and their Maori culture. This was also evidenced in care plans expressing the resident’s specific and individual needs in relation to their Maori culture and beliefs. The resident and relative/whanau interviewed confirmed that they were happy with the service and had no concerns. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs  Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs. | FA | The spiritual, religious and cultural standard operating procedure documents that the admission process includes assessing specific cultural, religious and spiritual beliefs, which includes any cultural nutrition requirements. Staff are required to liaise with family/whanau within one week of admission to ensure cultural or religious visits continue as appropriate.  Education on cultural sensitivity and death and spirituality was recently completed as part of staff two year compulsory training. Families and relatives interviewed were happy with the care provided by those staff who also identify with a different culture and enjoy different cultural days that are organised within the facility. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Family/whanau and residents reported that they are very happy with the care provided. The families/whanau expressed that staff know their relatives well, that relationships are built while professional boundaries are maintained. No concerns were reported. Staff interviewed stated that professional boundaries was discussed as part of their orientation programme as evidenced in the induction book. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | Evidence-based practice was observed and evidenced in interviews with the clinical coordinator/RN and caregivers and care planning. Policies and procedures that are linked to evidence-based practice include regular visits by residents GPs, links with the mental health services, hospice, geriatrician and the DHB care guidelines all of which are utilised as appropriate. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. All residents and relatives who do not speak English shall be advised of the availability of an interpreter at the first point of contact with staff.  At the time of audit all residents and relatives spoke English and did not require interpreting services.  The family/whanau interviewed confirmed that they are kept informed of their relative’s wellbeing including any incidence adversely affecting their relative and were happy with the timeframes that this occurred. Evidence of timely open disclosure was seen in the resident’s progress notes, accident/incident forms, from an observed phone call to a relative, and at handover. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The TerraNova group is overseen by a chief executive officer (CEO) who has been in the role for five months, has extensive experience in the NZ health sector and is qualified in business management and leadership. The CEO provides written reports to the board each month and meets with them at formal board meetings every three months. The CEO reports that the board is very invested in all TerraNova facilities presenting a consistent appearance in regards to the environment and a high standard of care.  The facility manager of Monte Vista Residential Care is a NZ registered nurse (RN) with a current practising certificate who has extensive experience as a manager in the aged care sector. All management staff maintain essential skills and knowledge for the roles they hold by attending regular professional development and industry conferences. The manager is well supported by executive management during weekly teleconferences and four-six weekly face to face meetings. Information about operations including clinical data, occupancy, staffing and finances is reported via a balanced scorecard to head office each month. This provides targets for performance.  On the days of audit there were 13 residents requiring rest home level care and 17 residents requiring hospital level care. There are 40 rooms designated for dual use as either rest home or hospital.  The organisation has a clearly defined scope, direction and goals documented in the service marketing literature and the 2015 business plan and quality and risk plan. |
| Standard 1.2.2: Service Management  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. | FA | The ‘Clinical Compass’ model being used, delegates service delivery tasks to care staff teams with designated leaders (RNs and senior caregivers). Each leader has a portfolio that covers an aspect of service delivery such as documentation, hazard management, health & safety, pharmacy, restraint minimisation and safe practice, infection control, clinical procedures, orientation and training, audits, manual handling, service supplies and laundry services. Clinical Compass aims to ensure service delivery is consistent, efficient and effective. Monte Vista demonstrates that services are being provided safely and appropriately as required to their residents.  Temporary cover during the manager’s planned absences is carried out by the clinical coordinator. This arrangement has proven to be effective and ensures continuity for staff, residents and their families. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk management system is integrated with service delivery and reflects continuous quality improvement. A document review of policies, procedures and forms confirms that documents are controlled and policies are current and reflect best known practices. There is evidence that policies are reviewed at least every two years in a controlled and informed way. Policies are available in hard copy or stored electronically in a shared information management system to eliminate the use of obsolete documents.  The service conducts internal audits against all areas of service delivery (eg, clinical records, complaints, food, housekeeping, medicines, activities, resident care, and restraint and infection control). All staff interviewed understood their role in relation to the system. Results of audits are reliably reported to staff, along with incident and accident data at monthly staff meetings. Where improvements are required these are discussed, actions are agreed and implementation is monitored by the facility manager.  All risks are recorded on the Risk Management Plan. These are identified through staff, resident and family meetings, individual reports, health and safety reporting, concerns/complaints, the internal audit programme, external auditing and participation in any benchmarking programmes (such as for infection control). The facility submits monthly risk reports to the governing organisation which detail clinical risks, staffing, bed numbers, incidents and other risk factors. |
| 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 family/whānau of choice in an open manner. | FA | The incident and accident reporting policy contains clear and descriptive processes for the reporting, recording, investigation and review of events. Observation on the days of audit and interviews with the manager and the clinical coordinator confirmed that all incidents are evaluated and actions are implemented to prevent recurrence. Reported events (falls, medicine errors, verbal or physical aggression) are discussed at shift handover. The RNs look at these in detail at their meetings and all staff are informed about trends at monthly staff meetings. Each resident’s file contained incident reports which facilitates a ready review of individual risks.  There is rating of continuous improvement in this standard for the positive outcomes from the implementation of new strategies to reduce the number of falls in the identified ‘frequent faller’ group of residents. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There was evidence in six personnel records that recruitment for new staff adheres to best known employment processes (eg, formal interview, verification of qualifications, contacting referees and carrying out police checks before confirming an employment agreement). The records contained evidence that registered nurses have current practising certificates, all roles have a job description and that confidentiality agreements, codes of behaviour, and individual employment agreements were signed.  Interview with a new caregiver and the personnel records confirmed the orientation programme is tailored for different roles and includes all essential information. This includes a tour of the facility, ‘buddy’ shifts with a staff member and commencement of tasks as designated. A competency and suitability appraisal is completed after three months.  The service is rated continuous improvement for achievements in staff training. In-service education in the care of older people is regular and ongoing. This is provided on site by the RNs, the manager or external experts and there is also organisational wide sessions provided for specific groups of staff (eg, clinical coordinators and managers). All staff must attend a compulsory training day in privacy, cultural sensitivity, health and safety, death and spirituality, manual handling and stress management at least every two years. All levels of staff are maintaining certificates in first aid and the staff who are authorised to administer medicines are competency assessed at least annually. Monte Vista has implemented a quality initiative to increase the number of staff who hold qualifications in aged care. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service demonstrates that there are sufficient numbers of skilled and experienced staff to meet the individual needs of hospital and rest home level care residents. There is at least one RN on site 24 hours a day seven days a week and another on call. The number of care staff on the shift is increased when the number of hospital care residents rises to above 20. Caregivers and RNs interviewed confirmed that ‘short shift’ staff work additional hours when workloads are temporarily higher. The organisation uses ‘time target’ for monitoring staff hours and as a communication tool. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all resident's information sighted. Clinical notes were current and integrated with GP and auxiliary staff notes. The files were being kept secure and only accessible to authorised people. On the day of admission all relevant information is entered into the resident's file by the RN following an initial assessment and medical examination by the GP. The date of admission, full and preferred name, next of kin, date of birth, gender, ethnicity/religion, NHI, the name of the GP, authorised power of attorney, allergies, next of kin and phone numbers were all completed in each resident’s record reviewed. No personal or private resident information was observed to be on public display during the days of audit  Archived records were being safely held on site for four years and then sent to another site for six years until approved for destruction. These are catalogued for easy retrieval. |
| Standard 1.3.1: Entry To Services  Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | The service has an admission/enquiry form that records pre-admission information. At the time of the audit the service has one resident under the age of 65. When an enquiry is made, it is then entered into computer programme which holds a record of the enquires. The resident admission agreement is based on the Aged Care Association agreement which is individualised to the service. The resident’s records reviewed have signed admission agreements by the resident/family or EPOA.  The entry criteria were sighted and the services website clearly identifies what services are provided. Vacancies are updated daily through Eldernet and TerraNova also has their own web site. Staff have been educated and have guidelines to deal with enquiries after hours and in the weekends; this is reported by the manager/RN as being successful. Staff interviewed state that they feel more confident in helping visitors with enquiries. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The service uses the DHB’s processes and forms for admission and discharge to and from the acute care hospital which includes a transfer template, envelope and check list requiring specific information to accompany the resident. This form requests information on all aspects of care provision, known risks and intervention requirements. A copy of the resident’s individual risk profile, individual file front page, medication profile form and allergies records, a summary of medical notes and a copy of any advance directives are also included. Communication between the two services and with the family occurs prior to transfer and any concerns are documented and included in the transfer information. |
| 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 | The medication management policy and procedure clearly describes the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, process when and error occurs as well as definitions for ‘over the counter’ medications that may be required by residents. The sighted policies meet the legislative requirements and best practice guidelines.  Medications for residents are received and delivered by the pharmacy in a pre-packed delivery system. A safe system for medicine management was observed on the day of audit. Medicines are stored in locked medicine trolleys and in a locked room. Medications that require refrigeration are stored in a separate and locked fridge.  The 12 medicine charts reviewed have been reviewed by the GP every three months and are recorded on the medicine chart. All prescriptions sighted contained the date, medicine name, dose and time of administration. All medicine charts have each medicine individually prescribed and ‘as required’ (prn) medications identified had the reason stated for the use of that medication. There is a specimen signature register maintained for all staff who administers medicines. All the medicine files reviewed have a photo of the resident to assist with the identification of the resident and a pharmacy medication/tablet identifying sheet.  There are documented competencies sighted for the staff (RN and caregivers) designated as responsible for medicine management. The RN administering medicines at the time of audit demonstrated competency related to medicine management. Senior caregivers are assessed six monthly to be competent with supporting RNs with medication as required. For example, checking of a controlled drug. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The Kitchen and Food Handling policy states that food handling areas and practices will meet the requirements of the Food Act 1981. It includes guidelines for cleaning with a separate cleaning schedule, temperature requirements, hygiene standards for staff, purchasing of food, checking, storage and waste handling. Regular monitoring and surveillance of the food preparation and hygiene is carried out. Food procurement, production, preparation, storage, delivery and disposal was sighted at the time of audit. Fridge and freezer recordings are observed daily and recorded and were sighted and meet the food safe requirements. Kitchen staff have undertaken food safety management education appropriate to service delivery  There is a four week rotating menu with summer and winter variations. The menu has been reviewed by a dietitian. Where unintentional weight loss is recorded, the resident is discussed with the GP and referred for a dietitian review.  A nutritional profile is completed for each resident by the RN upon entry and this information is shared with the kitchen staff with a copy remaining in the kitchen to ensure all needs, wants, dislikes and special diets of the resident are catered for. The kitchen is available for staff to provide residents with food and nutritional snacks 24 hours a day.  All meals are cooked and served directly from the kitchen at the time of the meal, with residents having the option of trays in their rooms. Residents were observed to be offered the choice of one of two main meals at lunch (main meal). Family/whanau and residents interviewed reported that they are very satisfied with the food and fluid services.  Positioned in the dining room is a button automated tea and coffee machine alongside a water filter that residents and families are able to access easily and at any time. |
| Standard 1.3.2: Declining Referral/Entry To Services  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. | FA | The manager/RN interviewed reported that the service do not refuse a resident if they have a suitable Needs Assessment and Service Coordination (NASC) assessment for the level of care and there is a bed available. In the event that the service cannot meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential accommodation can be found.  If the resident’s needs exceed the level of care provided, they are reassessed and an appropriate service is found for the resident. The resident agreement has a statement that indicates when a resident is required to leave the service. The admission agreement has a clause on when the agreement can be terminated and the need for reassessment if the service can no longer meet the needs of the resident. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The service has now implemented the electronic interRAI assessment for all residents. The service continues to use organisational paper based assessment tools to complement the interRAI assessment. Assessments are carried out by a RN appropriate to the level of care of the resident and include falls, skin integrity, and challenging behaviour, nutritional needs, continence, and communication, end of life, self-medication and pain assessments. The interRAI assessment is also utilised when a change of level in care is required.  The residents’ files reviewed have assessment information identifying behaviour particular to that resident which is obtained from prior place of living, services, the resident and where applicable the resident’s family and/or nominated representative. Where a need is identified, interventions for this are recorded on the care plan and external services are requested as required. All of the files reviewed have falls risk and pressure risk assessments.  The family/whanau interviewed reported their resident receives ‘above and beyond the care required’ to meet their relative’s needs. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The six residents’ files reviewed have care plans that address the resident’s current abilities, concerns, routines, habits and level of independence. Strategies for reducing and minimising risk while promoting quality of life and independence are sited in the residents’ files. Also evidenced is the assessment of techniques used that is individual and specific to the resident with interventions and evaluations sighted. The caregivers interviewed demonstrated knowledge about the individual residents they care for.  Six residents’ files reviewed sighted diversional therapy care plans identifying the resident’s individual diversional, motivational and recreational requirements showing documented evidence of how these are managed. The files reviewed showed input from RNs, care and activities staff medical and allied health services. The RN and caregivers interviewed reported they receive adequate information to assist with the resident’s continuity of care. This was also evidenced in handover (verbal and paper) and staff communication book.  The family/whanau interviewed reported they were very happy with the quality of care provided at the service. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Clinical management policies and procedures include assessment on admission, weight and bowel management, clinical notes and referral information.  As observed on the day of the audit, RNs and caregivers demonstrated good knowledge of individual residents, providing individual and specific care that was reflected in the resident’s care plan. Staff were seen to pre-empt and redirect/distract residents with challenging behaviours promoting quality of life, independence, choices and safety of the residents as individuals and in group settings. The residents’ files showed evidence of discussions and involvement of family. The residents interviewed reported that the staff knew them all very well and had no concerns with the care they received.  The service has adequate dressing and continence supplies to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the resident’s assessed needs and desired goals. The RN and caregivers interviewed reported they have input into residents’ care plans on a regular basis and state that the care plans are accurate and kept up to date to reflect the resident’s needs. |
| Standard 1.3.7: Planned Activities  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. | FA | The activities programme uses a framework to empower the residents to have the opportunity to be valued and respected. The residents are provided with opportunities that are of interest to them from the past and present and are encouraged and supported to maintain their community networking and friendships allowing for ongoing socialisation and developing new interests. The activities coordinators adapt activities to meet the needs and choices of the resident.  The facility has two activity coordinators who work part-time. One staff member works Monday to Wednesday 0900-1630 and the second staff member works Thursday to Friday 0900-1630.  The weekly activities plan/calendar sighted is developed based on the residents’ needs and interests and can be easily adapted and changed depending on the residents’ interest and reaction at the time. The activity coordinator advertises the upcoming activities on the calendar by providing residents with a copy in their rooms and on the notice boards through the facility. The caregivers assist with the planned activities seven days a week. Regular activities include Ribbon/lace Club, Blokes shed and Gardening group, Chaplain Services. Van outings occur on a regular basis and include trips to the local library and other events occurring in the community. Daily activities occur within the main lounge. Activities focus on the five sensors and reminiscing, including current affairs. For residents that wish to remain in their rooms, activities and one to one interaction is offered and encouraged by staff. The care staff interviewed state that they have access to activities to support residents after hours and on the weekends.  The outside environment provides easy access to outside areas that enable residents to come and go safely. There are seating arrangements and different areas of focus.  The residents’ files reviewed have activities and social assessments that identify the resident’s individual diversional, motivational and recreational requirements over a 24 hour period. Daily activities attendance sheet records are maintained for each resident and is assessed and reviewed based on the enjoyment and interest of the resident. The goals are updated and evaluated in each resident’s file six monthly.  Family/whanau interviewed report that they are always encouraged to partake in the activities with their residents and supported when taking their relatives out into the community. Family/whanau report that there is a wide range of interesting and different exciting activities and events that occur. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The residents’ files reviewed had a documented evaluation that was conducted within the last six months. Evaluations are resident focused and document achievements or response to supports/interventions and progress towards meeting the desired outcome/goal.  Residents’ changing needs are clearly documented in the care plans reviewed. Residents whose health status changes, and/or is not responding to the services/interventions being delivered, are discussed with their GP and family/whanau. Short term care plans are sighted for wound care, pain, infections, and changes in mobility, changes in food and fluid intake and skin care. The medical and nursing assessments of these short term care plans are documented in the residents’ progress notes. The caregivers interviewed demonstrated good knowledge of short term care plans and reported that they are reported and discussed at handover.  Family/whanau interviewed stated that they can consult with staff at any time if they have concerns or there are changes in the resident’s condition. |
| Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)  Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs. | FA | There are 15 GPs who either visit the resident at the facility or a family member will take the resident to see the GP in the practice when required due to resident’s choice. The RN or the GP arrange for any referrals required to specialist medical services when necessary. Records of progress are recorded in the resident’s file and were observed. These referrals and consultations included mental health services, general medicine services, psychiatrist, radiology, geriatrician, podiatry and dietitian. The GP interviewed reported that referrals to requested services are well managed from the facility and no concerns are noted. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances  Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | The hotel services manual provides documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation the requirements of this standard and the Aged Residential Care (ARC) contract.  Visual inspection on the days of audit revealed that chemicals were stored securely and that there is safe disposable of body waste and contaminated or potentially infectious products. There was one sluice room on site and visual inspection showed this was clean and functional. Personal protective equipment is available and seen to be used on the days of audit.  Staff interviewed demonstrated knowledge and understanding of safety issues around managing waste and hazardous substances. Staff are being provided with ongoing information, education and support by the organisation and external suppliers. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building is very well maintained and fit for purpose. There is a current building warrant of fitness which expires in April 2016.  Interview with the facility services manager, maintenance staff and review of records and observations on the days of audit showed that electrical testing and tagging is completed by a certified electrician, and that calibrations of scales and medical equipment occurs. Fire safety equipment and hoists are regularly checked for safety. Residents were observed to be mobilising freely throughout the facility. Handrails and grab rails are installed throughout. Effective internal lighting and one run carpet is minimising risk of harm.  All external areas were inspected and appeared safe. A new perimeter fence has been installed since the previous audit to eliminate any risk to residents. The service uses community vehicles for outings which are warranted and registered. |
| Standard 1.4.3: Toilet, Shower, And Bathing Facilities  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. | FA | Five of the 40 bedrooms have toilet and shower ensuites and five have a toilet ensuite. Shared toilet/bathing/shower facilities are used where full staff support is required. There have been no issues with maintaining consumer privacy when attending to personal hygiene needs. Hot water monitoring is occurring monthly and temperatures are well within safe limits of below 45 degrees. Residents and families interviewed were very happy with the facilities. |
| Standard 1.4.4: Personal Space/Bed Areas  Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting. | FA | All rooms have a single occupant in them. The rooms are spacious and contain a single bed, television, at least one easy chair, wardrobe and clothes storage units and a bedside table. There is enough room for the resident to move around safely with or without a mobility aid. Bedrooms are refurbished and furnished according to the organisation’s specifications and design as they become available. Residents and families interviewed were very happy with the facilities. The service meets the requirement of the ARC contract and this standard. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining  Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | Each wing has a sitting area or lounge. The main lounge and dining room are located within easy walking distance from the residents’ bedrooms. |
| Standard 1.4.6: Cleaning And Laundry Services  Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | Laundry and cleaning services have clearly described standard operating procedures for daily and other routine tasks. These services are audited six monthly for effectiveness and compliance with policy. Feedback from residents and relatives is encouraged and responded to. The cleaner and the laundry person are allocated five hours a day to complete tasks and both staff interviewed said this was manageable with the current number of residents. When resident numbers increase, laundry and cleaning hours are reviewed and increased to acknowledge the extra work demand. Staff have attended safe chemical handling. All chemicals are decanted as needed into the appropriately labelled container. Visual observations showed that the laundry and cleaning areas are kept secure and clean. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The service has clearly documented emergency plans, and the emergency and security systems are well established and known by staff. There is an approved fire evacuation scheme dated January 2015. Fire drills are occurring every six months and staff attendance is monitored. Staff receive sufficient information on emergency procedures at orientation and there is ongoing training about civil defence processes and keeping residents safe during emergencies. The facility recently managed internal flooding of corridor in one of its wings due to the failure of a hot water system during the night. Staff stated that the emergency response by the NZ Fire service and plumbers was immediate and the hot water system was restored within the hour.  Review of staff training records and rosters and interview with the facility manager and staff showed there were sufficient numbers of registered nurses on site and on call twenty-four hours a day, seven days a week to manage emergencies. All staff are being supported to maintain certificates in first aid.  Interview with maintenance staff and inspection of the emergency/civil defence stores confirmed there was sufficient stock of water, food, equipment and essential supplies in the event of a natural disaster or power outage. The water holding system coped well with the recent hot water system malfunction. The ceiling water holding tanks contain 1300 litres and there is 40 litres of potable water on site. The facility has back up lighting. The call bell system was observed to be functional during the onsite audit and residents and families interviewed confirm that staff respond to call bells in a timely ways. There is no night security patrol but staff lock the external doors at dusk so entry to the facility is by ringing the front door bell. In all instances of security threat staff know to call 111. The provider meets the requirement of ARC contract. |
| Standard 1.4.8: Natural Light, Ventilation, And Heating  Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | Visual inspection revealed sufficiently sized windows and large opening doors for ventilation in all areas of the facility. Temperatures in all areas are moderated by electric heaters in common areas and panel heaters with individual controls in resident’s bedrooms. Bathrooms and toilets had functional heaters. Residents expressed satisfaction with the heating, light and ventilation of their rooms and the communal areas. |
| Standard 3.1: Infection control management  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. | FA | The service has a documented infection control programme which is reviewed as part of the annual quality review. The infection control programme minimises and reduces the risk of infections to residents, staff and visitors to the facility.  The infection control coordinator is the clinical coordinator/RN. The infection control coordinator holds accountability and responsibility for following the programme in the infection control manual. The infection control coordinator monitors for infections by using standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is discussed at each staff meetings. If there is an infectious outbreak this is reported immediately to staff, management and where required to the DHB and public health departments.  The infection control coordinator interviewed reported that staff have good assessment skills in the early identification of suspected infections. Residents with suspected and/or confirmed infections are reported to staff at handover and short term care plans implemented, and this is documented in the progress notes. Staff interviewed state that they are alerted to any concerns and are included in the management of reducing and minimising risk of infection through staff meetings, staff communication book, one to one, shift handover and in resident’s documented progress notes.  A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices found at entrances to the facility. When outbreaks are identified in the community, specific notices are placed at the entrance saying not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available and there are adequate hand washing facilities for staff, visitors and residents with hand washing signs noted throughout the facility. Gloves and gowns were observed and found in all showers and toilets. Residents who have infections are encouraged to stay in their rooms if required. |
| Standard 3.2: Implementing the infection control programme  There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The Clinical Coordinator/RN has the role of infection prevention and control coordinator. The infection control committee meets quarterly and reports any issues at staff meetings. There is no local external specialist advice on infection prevention but if and when required advice can be sought from different external sources including the laboratory diagnostic services and GP. The infection control coordinator has undertaken a course in infection prevention and control through the DHB. The RNs and caregivers interviewed demonstrated good knowledge of infection prevention and control. On several occasions throughout the audit good hand washing technique was observed. |
| Standard 3.3: Policies and procedures  Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | An infection control policy sets out the expectations the organisation uses to minimise infections. This is supported by an infection control manual and policies and procedures that support specific areas including antibiotic use, MRSA screening, bandaging, wound management, blood and body spills, cleaning, disinfection and sterilisation, laundry and standard precautions. Staff were observed demonstrating safe and appropriate infection prevention and control practices. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Infection control is integrated within the new employee induction manual. The RNs and caregivers interviewed were able to demonstrate good infection prevention and control techniques and awareness of standard precautions, such as hand washing. Hand washing of staff is reviewed regularly by the Clinical Coordinator. Infection control in-service education sessions are held and resident education is provided, as and when appropriate. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | All staff are required to take responsibility for surveillance activities as shown in policy. Monitoring is discussed in management meetings to reduce and minimise risk and ensure residents’ safety. The infection coordinator completes a monthly surveillance report. The service monitors urinary tract infections, soft tissue, eye, vomiting/diarrhoea, lower and upper respiratory tract infections, scabies/head lice. The monthly analysis of the infections includes comparison with the previous month, reason for increase or decrease, trends and actions taken to reduce infections. This information is fedback and discussed in staff meetings.  An external contractor benchmarks surveillance data with other facilities within the group. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The restraint minimisation policy identifies that an enabler is the use of any equipment, devices or furniture, voluntary and consented by the consumer following appropriate assessment that limits normal freedom of movement, with the intent of promoting independence, comfort and/or safety.  The policy states that the restraints approved are bedrails, ‘fall out’ chairs, harness, wedge and lap belts. On the days of audit the only interventions in use are bed rails and one resident who also requires a lap belt. Review of the records, interview with the restraint coordinator and residents and observations revealed that all enablers are voluntary. |
| Standard 2.2.1: Restraint approval and processes  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. | FA | The restraint minimisation policy identifies a designated Restraint Coordinator who has had education and training on restraint and is backed up by the chairperson of the restraint committee. It describes processes for restraint approval and review and the specific documentation required for recording restraint matters.  The restraint register is up to date and lists the name of the resident, the type of restraint or enabler, the date these were started and dates for review and the frequency of monitoring. On the days of audit the restraint register lists three residents with approval and consent to use a restraint intervention and six residents who have consented to the voluntary use of enablers.  Training records and interviews showed that all staff attend at least one education session on restraint each year and undergo competency tests which include completion of a questionnaire and observation of practice by the restraint coordinator. All new staff are provided with information about the restraint policy, philosophy and approach during their orientation.  The restraint coordinator interviewed, who has been in the role for three years demonstrated understanding of the documented role description. |
| Standard 2.2.2: Assessment  Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | Each of the resident records reviewed for restraint use, contained a comprehensive account of the assessment made prior to use. These included current falls risk, a history of incidents, alternatives tried and reasons for the assessment being conducted. Any risks associated with the bed rail or lap belt were identified and highlighted. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service has purchased two ‘low low’ beds and bed and chair sensor mats as strategies for preventing harm and reducing the use of restraints. The records show that alternatives are considered and trialled. The restraint register records the type of restraint in use, the frequency of monitoring and review and the date it was initiated. Monitoring records for each of the nine residents using restraints or enablers were reliably completed, including on and off times and care interventions carried out over a 24 hour period. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Documents, including two residents’ care records, and staff interviews confirmed that ongoing restraint use is appropriately evaluated and reviewed every three months, or earlier if indicated, by the restraint coordinator. Each restraint is also discussed at monthly staff meetings to determine the resident’s progress or any concerns with the use of the restraint. The restraint coordinator maintains ongoing communication with families and support to staff. The service provider has complied with the requirements of this standard. |
| Standard 2.2.5: Restraint Monitoring and Quality Review  Services demonstrate the monitoring and quality review of their use of restraint. | PA Low | The service conducts annual audits of resident restraint records to determine compliance with policy and also reports restraints data to head office. Restraints in use are also discussed at monthly staff meetings. Otherwise there is no formal quality review of restraint usage at a facility or organisational level. The restraint policy does not make clear the requirements as listed in (a) to (h) and in practice there are no regular overviews of restraint use or progress in reducing restraint locally or from an organisational perspective. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 2.2.5.1  Services conduct comprehensive reviews regularly, of all restraint practice in order to determine: (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education. | PA Low | Quality review is not described in the restraint policy. Although there are annual audits of restraint records to determine compliance with policy and restraint use is discussed at staff meetings, a formal quality review is not occurring in the facility or across the organisation. This indicates a missed opportunity for the restraint co coordinators within the organisation to support and learn from each other. | The service is not conducting regular quality reviews to determine the use of restraint or any trends. There is no stated or practised intent to reduce the use of restraint. Restraint coordinators do not have an expert forum to report or discuss any adverse events related to restraint or to consider current accepted practices or whether changes are required to staff training/education. | Review and amend the restraint policy to include a process for either a facility or organisational quality review of restraint usage. Ensure that the quality review takes into account all aspects as listed in this criterion.  180 days |

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

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | CI | The falls management programme lists eight residents on the falls register on the days of audit. Additions to the falls management programme since February 2015 include use of bed sensors and chair sensors which alert staff as soon as the resident begins to move. This has resulted in a 245% improvement (eg, reduction from 27 falls to 11 falls for the same time period). | The service is rated continuous improvement for the extent of the review and evaluation of each resident listed in the falls register and the successful outcome from the implementation of new strategies to reduce falls. |
| Criterion 1.2.7.5  A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | CI | Eight of the 14 caregivers have completed the National Certificate in Health, Disability and Age Support (core competencies level 3). Both the manager and the clinical coordinator are Careerforce assessors. The organisation offers career pathways for enrolled nurses (ENs), RNs, and clinical coordinators. | Terra Nova provide excellent career pathways for ENs, RNs, and clinical coordinators and support all staff to achieve professional qualifications. Monte Vista implemented a quality initiative in 2014 which has resulted in eight of 14 caregivers completing the National Certificate in Health, Disability and Age Support. |

End of the report.