# The Ultimate Care Group Limited - Rosedale Village Hospital

## Introduction

This report records the results of a Provisional 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:** The Ultimate Care Group Limited

**Premises audited:** Rosedale Village Hospital

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

**Dates of audit:** Start date: 23 November 2015 End date: 24 November 2015

**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:** 55

# 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.

## General overview of the audit

Rosedale Village Hospital is currently owned and operated as a private limited company and also owns the retirement village on site. The village provides rest home and hospital level care to a maximum of 74 residents. On the days of audit there are 35 hospital residents and 20 rest home residents. All apartments that are occupied under an Occupation Rights Agreement (ORA) have been approved to provide both rest home and hospital level care. On the days of this provisional audit there are four hospital and 20 rest home residents in the apartments receiving care at these levels.

The audit was undertaken as there is a planned change of ownership. This provisional audit was conducted against the Health and Disability Services Standards and the provider’s contract with the district health board.

There are no areas identified as requiring improving.

## Consumer rights

Staff interviewed demonstrated good knowledge and practice of respecting residents` rights in their day to day interactions. The prospective provider has aged care management experience and at interview was fully informed of the obligations of the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` Rights (the Code). Education is provided to all staff at orientation and is ongoing. Advocacy services are readily available and contact numbers are accessible. Interpreter services are available if required.

There were no residents who identify as Maori at the service at the time of the audit. There are no known barriers to Maori residents accessing the service. Services are planned to respect the individual culture, values and beliefs of the residents.

Written informed consents are obtained from the resident, family/whanau, enduring power of attorney (EPOA) as required. Signed informed consent forms were sighted in all residents` records reviewed.

Linkages with family/whanau and the community are encouraged and maintained.

The complaints management system is effective. Residents and their families were well informed about how to raise concerns. All complaints and concerns are logged in the complaint register, immediately acknowledged and investigated. There have been no complaint investigations by the Health and Disability Commissioner. There have been no Police, Accident Compensation Corporation (ACC) or Coroner investigations.

## Organisational management

Residents are receiving safe services that are well managed, planned and coordinated. Residents and their relatives reported being very satisfied with the care and services being provided.

Quality and risk management systems are coordinated by a quality team with support from the general manager. There is effective and integrated monitoring of all service delivery areas. The service is managing health and safety and risk matters in accordance with current safe best practice and legislation. There have been no serious adverse events. The event reporting system is well established, effective and known by staff.

Recruitment, selection and management of staff meets the requirements of these standards and New Zealand legislation. All staff attend regular ongoing education and training in subject areas that are specific to the residents being cared for. There are sufficient numbers of suitably qualified and experienced staff on site 24 hours a day seven days a week.

Consumer information is managed in ways that meets the requirements of the Health Records Standard. Archived or obsolete residents’ records are being stored safely and securely.

The prospective provider has no plans to change any organisational management systems and understands the requirements of the Health and Disability Services Standards. They have other facilities which all meet the requirements.

All current resident information is collected in an integrated record folder and stored in a safe place. Records reviewed are up-to-date. Archived records are stored securely and are able to be easily retrieved. Staff records are maintained by management and all education is recorded accurately.

## Continuum of service delivery

Pre-admission information clearly and accurately identifies the services offered. The service agreements are signed appropriately.

Services are provided by suitably qualified and skilled staff to meet the needs of residents. A comprehensive interRAI assessment is being implemented. Timeframes for the development of long term care plans are met. When there are changes in the resident`s needs, a short term care plan is developed and implemented to reflect this. Evaluations occur six monthly on all aspects of the care plan. There is a multidisciplinary team approach to service delivery and continuity of care is promoted.

The general practitioner reviews all residents medically at the required timeframes and more frequently as required. Referral to other health and disability services is planned and coordinated, based on the individual needs of the resident.

The service has a planned activities programme to meet the social and recreational needs of the residents. The programme is overseen by a qualified diversional therapist. Residents are encouraged to maintain links with family/whanau and the community.

A safe medication system was observed at the time of the audit. The staff responsible for medication management have completed annual competencies.

The residents` nutritional requirements are effectively met by the service with preferences and special diets being catered for appropriately. The service employs experienced staff who prepare the meals from a four week rotating summer/winter menu plan which has been approved by a registered dietitian.

## Safe and appropriate environment

The facility has a current Building Warrant of Fitness, Code Compliance Certificate and fire evacuation approval.

Cleaning and laundry services are provided to a high standard. Chemicals were stored appropriately.

Emergency and disaster planning has been undertaken and all building regulations, fire safety, emergency and security standards are met. Residents and families reported high satisfaction with the environment.

The prospective purchaser has no plans to implement any environmental changes at Rosedale Village.

## Restraint minimisation and safe practice

The organisation uses best known processes for determining safe and appropriate restraint and enabler use. On the days of audit the restraint register is up to date with all residents who required interventions for safety. The methods used for assessment, consent and approval, monitoring, evaluation and review meet the requirements of the Restraint Minimisation and Safe Practice Standards. The service has succeeded in safely reducing the number of restraint interventions in use.

The prospective provider understands the requirement of restraint minimisation and safe practice.

## Infection prevention and control

The infection prevention and control management system is appropriate for the complexity of the service. The programme is reviewed annually and implemented. Infection prevention and control reduces the risk of infections to residents, staff, family/whanau and visitors. The policies and procedures reflect current good practice. Staff are provided with relevant education, as are the residents, when appropriate.

The infection control nurse and the quality assurance manager complete a monthly surveillance programme, where infections data is collated, analysed and trended and compared with previous data. Where any trends are identified actions are implemented to reduce infections. The infection surveillance results are reported at the staff monthly meetings. An external infection prevention and control service provides education and advice as needed.

## Summary of attainment

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

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

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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 consumer 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). The service policy states the Code is displayed and available to residents and monitored to ensure the rights of residents are respected. New residents and family/whanau are given a copy of the Code on admission, in the information pack sighted. The Code is displayed in all service areas in full view of residents, caregivers and visitors to the facility.  Staff receive training on the Code at commencement of employment as part of the orientation/induction process. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice.  The Code is available in English, Maori and other languages for residents with English as a second language. |
| 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 | A detailed informed and voluntary consent policy is implemented. Systems are in place to ensure residents, and where appropriate their family/whanau, are provided with appropriate information to make informed choices and informed decisions. The registered nurses interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and understand informed consent processes and that appropriate information had been provided.  A multi-purpose informed consent form is utilised by the service provider and a copy is retained in each individual resident’s record reviewed. Additional forms, for example, for wound photographs, procedures, and for annual influenza vaccinations are in the records sighted. Forms were signed and dated appropriately. Full explanations were provided by the registered nurse or the GP.  The admission agreements were signed and dated by the provider and the resident and/or representative. The general manager ensured these were all signed, filed and stored appropriately.  The GP interviewed understands the obligations and legislative requirement to ensure competency of residents as required for advance directives and reviews are undertaken six monthly. Reviews of health status are documented on the multidisciplinary team meeting form available and retained in the individual resident`s record.  Nursing management and registered nurses interviewed reported they received orientation/induction in the principles and practice of informed consent as part of the Code of Rights and provided evidence of an understanding of the Code. |
| 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 is available to guide staff. The policy also makes reference to the Complaints procedure. All residents receiving care within this organisation have appropriate access to independent advice and support, including access to a cultural and/or spiritual advocate whenever required.  Family interviewed reported they were provided with all relevant information regarding access to advocacy services. Contact details of the Nationwide Health and Disability Advocacy Service is listed in the resident information pack provided. The contact numbers are also documented on the reverse of the Consumers` Rights brochure. Education for staff is conducted as part of the orientation programme and is ongoing and this was evidenced in the education programme and confirmed by the staff interviewed. |
| 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 | Visitors are able to visit anytime and families interviewed confirmed they are encouraged to visit. A visitor`s book is situated at reception and this was completed by visitors for health and safety reasons. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. Evidence was seen of this in the activity programme records and reported by residents interviewed. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints policy and procedures meet the requirements of the provider’s contract with the DHB and Right 10 of the Code. It also contains references to advocacy and the organisation’s quality system, resident’s rights, advocacy and resident/family meetings policies.  Review of the complaints register and interview with the general manager confirmed there have been complaints received since the previous audit and all have been dealt with using the internal system. Systems are in place to ensure residents and their families are advised on entry to the facility of the complaint processes and the Code. The residents and relatives interviewed demonstrated an understanding and awareness of complaint processes. Staff attend regular education on the Code of Rights, including the complaints processes. Review of residents’ meeting minutes provides evidence of discussion on the Code of Rights and complaints. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | 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 registered nurse go through the Code with the resident/family/whanau during the admission process.  The family/whanau members that were available for interview reported that the Code was explained to them on admission. Interviews with residents who were able to provide insight into their care, expressed that they were treated with respect and were happy at the facility.  An interpreter policy was reviewed and an interpreter service is available when required. The prospective provider interviewed has experience working in aged care and is understands consumer rights.  Evidence is seen of the Code of Rights being displayed throughout the facility. Staff demonstrated respect to all residents. Staff displayed knowledge of the Code during interviews. |
| 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 | The 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 as required. The wishes of residents are acknowledged, sexuality and personal rights are upheld, and independence maintained, maximised and encouraged.  The families interviewed reported that their relatives were treated in a manner showing regard to the resident`s dignity, privacy and independence.  The residents` records reviewed indicated that residents received appropriate services that were responsive to their needs, values and beliefs of culture, religion and ethnicity.  The families interviewed reported satisfaction with the way the service meets the needs of their relatives. Church services are provided at the facility on a regular basis.  As observed on the days of the audit and confirmed with review of the individual resident`s randomly selected records, residents receive services to meet their needs. No concerns were raised in relation to abuse and neglect from residents, the general practitioner, family and/or staff interviewed. Staff have received education and understood their responsibilities along with who to report to if abuse/neglect was suspected with a resident or a staff member. Comments received reflected a positive atmosphere from staff and family. |
| 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 organisation has a Maori Health Plan and Tikanga Best Practice Policy which acknowledges the primacy of the Treaty of Waitangi and states the service will provide an appropriate and effective health service for Maori people. 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 provision of culturally appropriate services and the identification and reduction of any barriers are part of the organisation’s Maori Health Plan objectives.  Guidelines are developed and implemented to ensure guidance is available for the provision of culturally safe services for Maori residents. This was reviewed in August 2014. Rooms can be blessed as required. There are no known barriers that exist for Maori residents to access this service.  There were no Maori residents or staff who identify as Maori at the time of the audit. The staff interviewed demonstrated good understanding of services that would need to be provided for Maori residents to meet identified needs, and the importance of whanau. |
| 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 policies and procedures provide information to guide staff on the correct protocol. A cultural needs assessment tool is available to ensure the identified needs can be effectively met. The registered nurses interviewed have an understanding of the four corner stones of Maori Health: unity of mind, soul, body and family, (physical Te Taha Tinana, spiritual TeTaha Wairua, mental e Taha Hinengaro, family Te Taha Whanua). Together these components blended to form an integrated and comprehensive model of health and well-being for Maori residents.  Staff interviewed reported they received training in cultural awareness. The Cultural Responsiveness Policy sighted ensured the cultural values and beliefs of all residents at this facility were able to be met. Staff interviewed recognised and respected these cultural needs in their everyday practices. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | The staff files reviewed had job descriptions and employment agreements that have clear guidelines regarding professional boundaries. House rules are also part of the employment agreement and staff responsibilities were reviewed. There are clear definitions of types of discrimination in the service discrimination policy sighted. There are key objectives to be upheld for residents.  All registered nurses have completed the professional boundaries workshops which is a requirement for the New Zealand Nursing Council. The family/whanau/residents interviewed reported they are pleased with the care provided. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | The registered nurses promote and encourage best practice with staff. Evidence of this was demonstrated in interviews with the registered nurses. The recent implementation of the handover book and the benefits for open communication has been successful and this was discussed with the healthcare assistants interviewed. Policies and procedures are managed effectively by the quality assurance manager in consultation with staff. All policies and procedures where applicable are linked to evidence-based practice.  The general practitioner interviewed is pleased to have discussions with family if and when required and to visit residents as needed. The family and residents interviewed reported satisfaction with the services and care provided. |
| 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. The cultural appropriateness procedure documents that residents and families who do not speak English shall be advised of the availability of an interpreter at the first point of contact with the service.  The service promotes an environment that optimises communication and staff education related to appropriate communication methods.  Family interviewed confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. Evidence of open disclosure is documented in the residents’ files reviewed, on the accident/incident form and in the residents` progress notes. |
| 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 Business Plan 2015-2016 includes the service purpose, philosophy and values, scope and a ‘strengths, weaknesses, opportunities, threats’ exercise, and current goals with time framed action strategies which have responsibilities allocated. Interview with the general manager (GM) and the quality assurance facilitator (QAF) revealed that the owners are closely involved with village matters.  The GM is a registered nurse with a current practising certificate. This person has been in this role for four years. Personnel records and interview with the GM confirmed that her nursing portfolio, clinical skills and knowledge are maintained by attending networking meetings with other aged care providers and regular professional development/education in subject areas related to rest home management and care of older people. The manager is supported by other QAFs, a clinical facilitator, RN’s and administrative staff with financial, quality/risk and clinical service delivery tasks.  The prospective provider has other facilities and has an established organisational structure, including governance and management. During interview the prospective provider reported that there are no plans to change key personnel and they will continue the current staffing arrangements. If changes are planned for the future the provider is aware of all regulatory requirements. The transition plan is for change of ownership in January 2016 and there are no planned changes to the service or staff. |
| 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 service has appropriate systems in place to ensure the day-to-day operations of the service continue should the manager be absent. The GM role is delegated to the QAF or the clinical facilitator with input from others as required.  The prospective provider reported that there will be no changes to service management and rosters. |
| 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 service continues to strengthen and improve its quality and risk activities. Quality and business activities are integrated and co-ordinated across all aspects of service delivery. The GM and quality team meet monthly to consider quality and risk matters. Minutes of these meetings revealed that quality data, such as accidents/incidents, complaints, infection rates, results from internal audits and feedback from resident/family meetings and resident plan reviews are considered. Action plans were developed where the need for service improvements are identified and there was evidence these were monitored for implementation and closure at quality meetings. A narrative and statistical report on quality and risk matters is being reported to the owners monthly. Other staff meetings included discussion and reporting on incidents, infections, safety and restraint matters. All staff interviewed demonstrated understanding and involvement in the quality and risk systems.  Risk management and occupational health and safety processes are clearly described. The risk management plan identifies all actual and potential business and environmental risks. The sighted hazard register is being maintained by the health and safety officer, who conducts regular environmental inspections and supports and educates staff on health and safety matters.  The prospective purchaser is not planning any changes to operations (both clinical and/or operational) and understands regulatory requirements changes happen in the future. |
| 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 adverse event reporting system is a planned and co-ordinated process. Staff document all adverse, unplanned or untoward events on incident forms. These are reported verbally at handover and in the written summary. Incidents are reviewed by the RNs who document follow up actions. A summary of categorised events is submitted to the GM who reports these to the staff monthly. There have been no notifiable events. There was evidence in the sample of records reviewed and in interviews that staff understand and implement open disclosure practices by acknowledging and notifying events to effected parties. The service complies with the contractual (ARC) requirements.  The prospective purchaser reported that there are no compliance issues which could affect the service. |
| 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 | Human resources policies and guidelines for recruitment and staff management comply with legislation and good employment practices. Professional qualifications are validated before commencement of employment. Copies of the RNs’ current practising certificates were seen on files. New staff are being recruited according to good employment practices which includes formal interviews, police checking and referee checks. Evidence of this was sighted in the personnel records reviewed.  All new staff engage in a comprehensive orientation programme specific to their role. The programme includes training and competency assessments in emergency systems. A recently employed health care assistant stated the induction and orientation was providing the necessary skills and confidence.  Staff learning and development is planned by the GM and the QAF. In-service education sessions on a range of different topics are scheduled over a two year period and include individual achievements with Aged Care Education (ACE). Staff records reviewed contained a running record of education attended. There has been good progress in engaging staff with education. The GM attends at least eight hours of training as required in the provider’s contract with the DHB.  Staff who are authorised to administer medicines are being competency assessed annually. All staff engage in regular performance appraisals as required by the contract.  A quality initiative implemented has been to give each RN an area of responsibility and set up a portfolio. These areas include infection control, restraint, wound management, medications and new forms. The RNs reported on interview they are enjoying the extra responsibility and are given time to work on the portfolio. |
| 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 provider availability policy describes the service approach to staffing. It states that staffing will be evaluated at least annually or when change occurs in residents, core business, goals or size.  There are sufficient numbers of skilled and experienced staff rostered to meet the needs of the maximum number of residents. This wing is staffed with one RN on the floor 24 hours a day and seven days a week (24/7) plus the QAF and the clinical facilitator work 32-40 hours per week. There are sufficient health care assistants rostered on each shift to ensure safe staffing levels.  The GM is employed to work five days a week between the hours of 8 am to 5 pm and is on call (24/7).  Care staff numbers are flexible according to the number of residents and their acuity (level of need). Staff provided for the ORA are from the care facility and this ensures safe staffing numbers to both areas.  There are cooks who work various hours seven days a week. The activities co-ordinators are employed over flexible hours to provide group and individual activities. Volunteers must complete an orientation programme and sign confidentiality agreements. Other allied staff (eg, cleaners, laundry staff, administrators and maintenance/grounds staff) are employed for enough hours to complete tasks.  The prospective provider has confirmed by interview that the current staffing regime will be maintained to ensure continuing safe practices. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Personal information is entered in all residents’ records reviewed. Entries are documented clearly and are legible with signatures and designation as required. All records are integrated. The resident register is maintained. Resident current records are stored appropriately and securely in two locked nurses` offices, one located upstairs in the hospital wing and one downstairs. Resident information is not displayed in public view. Resident`s names are on each doorway with consent of the resident on entry to the service.  Staff files are maintained by the general manager. Contents pages are in the front of each individual staff and resident records sighted. Information is able to be retrieved as required. A system is in place for accessing archived records if and when needed. |
| 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 administrator has an admission/enquiry form for recording all pre-admission information. There is a comprehensive resident`s information pack available for this care setting. There is adequate information about the services provided along with the contact details of the service, the general manager and the quality assurance facilitator.  The resident agreement is based on the Aged Care Association agreement which is individualised to the service. The residents` agreements are signed and dated and stored separately in the general manager`s office. The admission agreement identifies any additional charges that are not covered by the service agreement and the relevant costs of each charge required. Incontinence products are only charged if the resident or family chooses a brand different to those provided by the facility.  All residents at the facility have been pre-assessed prior to admission as requiring either rest home or hospital level care. The District Health Board Needs Assessor Service Co-ordinators (NASC) ensure the interRAI pre-assessment documentation is made available to the nursing staff when a resident is admitted to the service. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | The registered nurses interviewed stated that risks are identified prior to any discharges being planned for a resident. A transfer form is used and the `yellow bag system`, a DHB requirement, is utilised. The registered nurses ensure open disclosure between services and family/whanau related to all aspects of service delivery occurs. This includes residents for either discharge and/or transfer to another facility or to the DHB.  If there are any specific requests or concerns that the resident or family want discussed, these are noted on the transfer form. The discharge form and care plan summary is provided and covers all personal cares or needs of the resident and any interventions required. Any identified known risks, alerts or concerns are highlighted. If a transfer occurs a copy of the medication record with any known allergies and/or sensitivities, the resident information page and/any advanced directives also accompany the resident if they are transferred to hospital. |
| 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 policies are accessible to guide staff as required. The sighted policies meet the legislative and best practice guidelines. All medications are managed by the registered nurses and three senior healthcare assistants. The registered nurses and two managers have completed annual medication competencies. The three healthcare assistants have checking competencies.  Medicines are received from the contracted pharmacy in a pre-packed delivery system. The medications are checked by the registered nurse on duty. The medications are stored in the two lockable medication trollies available and stored in the nurse`s station office, when not in use. Controlled drugs are checked weekly and the register is maintained. A controlled sticker is used on each of the medications in the locked cupboard. A signature specimen list is now in the controlled drug register. A controlled medicine audit was performed last by the pharmacy in November 2015. There is a clear process for medication/incident events.  A safe system for medicine management was observed on the day of the audit. The GP interviewed stated that there have been no significant medication errors in which the GP has been involved. The registered nurses only contact the GP with any queries or points of clarification as needed. The DHB pharmacist for aged care has also performed reconciliation audits and provided recommendations to the GP as required. This is a newly implemented initiative provided by the DHB.  The medication records randomly selected and reviewed have been reviewed by the GP on a regular basis and records are maintained. All medicines are prescribed individually on the records reviewed. There is a staff signature specimen list maintained for all staff who administer medicines in the front of the medication record books in each area of service. Photographic identification is evident on all medication records. The medication signing records are completed by the pharmacist and as each medication is administered it is signed off by the registered nurse. Medication returns to the pharmacy are recorded and monitored and the date when collected by the pharmacist is documented.  Medication fridge storage is monitored. There is only one resident who self-medicates medication. A self-medicating review is completed by the GP. A self-medication policy is documented and implemented. A schedule was sighted for administration of Vitamin B12 injections to be administered three monthly by the registered nurses. |
| 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 staff interviewed (one chef and two kitchen hands) work Monday to Friday and a cook and a trained kitchenhand work the two days in the weekend and provide relief as required. All kitchen staff are fully informed about food handling and practices to meet legislative requirements. The food safety management education undertaken is appropriate to service delivery. A menu audit was completed by a consultant registered dietitian and a letter was able to be validated (May 2013). The dietitian is available on a referral basis. The menu rotates and summer and winter menus are prepared.  Policies, procedures and guidelines are available that are current and up-to-date and include a separate cleaning schedule, temperature monitoring requirements, hygiene standards for staff, purchasing of food, checking deliveries, storage and waste management.  Regular monitoring and surveillance of the food preparation and hygiene is performed. The kitchen is well designed, clean and functional. A nutritional profile is completed as part of the admission process and this information is shared with the chef to ensure all needs, wants, preferences and special diets/days are catered for.  Annual service surveys completed by residents/family include the food service. The families and residents interviewed reported satisfaction with the meal service.  All aspects of food procurement production, preparation, storage, delivery and disposal complies with current legislation and guidelines. There is evidence of fridge/freezer temperature recordings which meet food safety requirements. |
| 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 registered nurse interviewed reported that the service does not refuse a resident if they have a suitable needs assessment service coordinators assessment (NASC) for the level of care and that there is a be available.  In the event that the service cannot safely meet the needs of the resident, the resident, family and NASC service will be contacted so that alternative residential care accommodation can be arranged. This could occur, as an example, in the event of a resident requiring a secure dementia service for ongoing dementia care. The GP interviewed would ensure the appropriate referrals for re-assessment are arranged. The service provides rest home and hospital level care. The resident register would be updated if a resident is discharged to another facility. The registered nurses are responsible for completing an interRAI assessment when required. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | All new residents admitted to the service have and interRAI assessment or this is in progress. The assessment include review of any previous interRAI assessments, such as homecare and/or needs assessment service coordinator’s comments. Any additional assessments are completed, such as pain, cultural, skin pressure areas prevention, falls risk assessments, nutritional and other assessments, depending on identified needs for the individual resident.  The residents` records randomly reviewed evidenced electronic assessments are currently printed off and included in the hard copy residents` records. Results of the assessments are discussed with the resident and family/whanau and included in the care plan as ‘needs’ with appropriate interventions.  Residents, staff and families interviewed reported appropriate care is provided that meets identified support needs and preferences. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The residents` records reviewed have care plans that address the resident`s abilities, level of independence, identified needs/deficits, and takes into account the resident`s habits and idiosyncrasies. The strategies minimising falls risk on assessment and use of techniques that are effective were evidenced in the records reviewed. The interRAI assessment has a summary which includes triggered outcome scores and the needs, identified by the registered nurse completing the individual assessment. These findings are documented as available onto the existing care plan.  The general manager and the quality assurance manager interviewed demonstrated they understand the interRAI process and this will be continued to be implemented as required.  The individual care plans and individual activities plans reviewed identified resident`s activities, motivational and recreational requirements with documented evidence of how these are managed effectively for each individual resident. The qualified diversional therapist and two activities co-ordinators interviewed provided insight on how the activities programme interventions were developed to meet the needs for residents. Group and one on one activities are arranged.  The records sighted demonstrated integration with dividers between each section and a contents page with a list of contents.  The registered nurses, GP and healthcare assistants interviewed reported they receive adequate information to assist with the continuity of care and service delivery for each individual resident. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | As observed during the audit and from review of the care plans, support and care was individualised and focused on achieving desired outcomes/goals set. The registered nurses and healthcare assistants interviewed demonstrated appropriate skills and knowledge of the individual needs of residents. The records sighted showed evidence of consultation and involvement with the resident and family as able. The residents interviewed reported satisfaction with the care and services provided.  Short term care plans are developed as necessary for any event that is not part of the care plan, such as weight loss and wound/skin tears management. The registered nurses ensure the GP is kept well informed of progress.  The service has adequate stocks of wound and continence products to meet the needs of the residents. The care plans reviewed recorded interventions that are consistent with the residents` needs being able to be met. Observations on the day of audit indicated residents are receiving care that is consistent with their needs. The registered nurses interviewed reported that all care plan interventions are accurate and kept up to date. Each registered nurse is allocated a number of residents to be responsible for from admission and in the longer term. |
| 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 ensures resident’s individual motivational, recreational and cultural needs are recognised. Each resident is assessed on admission by the qualified diversional therapist. The residents have the opportunity to maintain interests, choices and activities in a continuing care environment. The diversional therapist and two activities co-ordinators discussed the activities programme, how it is developed and implemented. The programme sighted is based on the residents` needs, interests, skills and strengths and covers cognitive, physical and social needs.  The activities programme is planned monthly but displayed weekly. A copy of the programme is displayed in each area of service and by the dining rooms. Residents and families can access the information displayed. A resident meeting is held regularly and minutes of the meetings are maintained and were sighted.  The activities co-ordinators maintain attendance records of each resident`s participation. The activities staff are mindful that resident participation is voluntary and this is respected. One on one activities are arranged for the hospital level residents who are unable to attend the group sessions. Each resident has their own activities plan which is reviewed six monthly. The activities co-ordinators and the diversional therapist provide updates on each resident as part of the multidisciplinary team meeting. The staff ensure goals are achievable and updated as required.  Residents are encouraged to maintain links with the community and family. The service has a bus and a van for external activities and outings in the community. Special days are celebrated, for example birthdays, cultural days, anniversaries and other special events.  Christian groups visit and church services are held weekly. Communion can be arranged.  Residents were visibly enjoying the activities seen during the audit and residents interviewed reported that they enjoy the range and variety of planned activities arranged. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Service delivery plans, such as the care and activities plans, are reviewed six monthly or more often if required. Evaluations are resident focused and indicate the degree of achievement or response to supports/interventions and progress towards meeting the set goals. If a resident is not responding to the services/interventions being delivered, or their health status changes, then this is discussed with the GP. Residents` changing needs are clearly described in the care plans reviewed. Short term care plans are instigated on the short term plan provided and are retained in a separate folder in each service area, medical and nursing notes and the resident`s progress notes.  The healthcare assistants interviewed demonstrated good knowledge of short term care plans and reported that these are identified and information is shared in the handover book and handover between the shifts. Progress is also discussed as part of the six monthly multidisciplinary team reviews.  Families reported that they are consulted when staff have any concerns or when there are changes in the resident`s condition. This is documented on the family contact record sheet evidenced in all records reviewed. |
| 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 | Residents are provided with options if required to access other health and disability services. There is a GP who is contracted to the facility and the GP visits regularly twice a week. The GP visits after hours if required and covers twenty four hours a day seven days a week. The GP interviewed arranges any referrals to specialist medical or surgical services as necessary. There is a process for transferring residents if and when required. The DHB referral system (yellow bag system) is followed through and is a guide for the GP and staff after hours.  The registered nurses interviewed reported that referral services respond promptly to referrals sent. Records of the processes maintained is able to be confirmed in resident`s records reviewed which includes referrals and consultations with eye specialists, orthopaedic specialists, geriatricians, portable x-ray radiologists, nurse practitioners, gerontology nurse specialists, physiotherapist, podiatrist and/or dietitian services. The GP interviewed reported that appropriate referrals to other health and disability services are well managed. |
| 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 | Policy and procedures contain correct disposal methods about all types of human and domestic waste. These also include standards about chemical labelling, the use of protective clothing and equipment and reporting of spills incidents. Chemical Material Safety Data sheets are available and accessible for staff. The hazard register is current. Review of staff training records and interviews with the chemical supply contractor and care staff who carry out cleaning and laundry duties confirmed that regular training and education on the safe and appropriate handling of waste and hazardous substances occurs. Visual inspection throughout the facility and observations of staff during both audit days reveals that protective clothing and equipment (eg, gloves and aprons, footwear, and masks) is provided. All chemicals were being stored securely and decanted into clearly labelled containers. The chemical supply company visits each month to check that staff are managing chemicals safely and efficiently and undertake an audit. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. Handrails are installed in corridors, showers and toilets to promote safe mobilisation. All external areas inspected were safe, secure and contain appropriate seating and shade. The facility is being maintained in good repair. Medical equipment is checked and calibrated regularly (eg, sphygmomanometer, scales and hoists). The current Building Warrant of Fitness expires on 12 October 2016.  The prospective provider has no plans to change the environment and is aware of the regulatory requirements should a decision be made to do so in the future. |
| 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 | There are sufficient numbers of toilets and bathrooms for the number of residents. Some bedrooms have attached ensuite bathrooms with a toilet and hand basin, otherwise the residents use communal bathrooms or a shared toilet. All the bathrooms and toilets are being maintained to a good standard, are disability accessible with easy to clean walls and floor surfaces, detachable shower heads and electric heaters. Hot water temperatures are being monitored monthly. Review of the records and hand testing at tap sites reveals temperatures are all below 45 degrees Celsius. |
| 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 bedrooms are designated as single occupancy. Bedrooms are spacious and being kept clutter free. The apartments in the village are spacious and can provide hospital or rest home level care. The larger rooms in the hospital have, ensuite toilets hand basins and are furnished with high low beds. Furnishings are in an excellent condition. |
| 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 of the area has its own lounge area as well as a large communal dining and lounge area. One end of this room is used for day time activities. Residents who do not want to participate in group activities are offered one on one time in their bedrooms or may avoid disturbance by sitting in another area. Dining rooms and lounges are within easy walking distances to bedrooms. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet times. All furniture is safe and suitable for the consumer group. |
| 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 | Sufficient numbers of cleaning and laundry staff are allocated enough hours seven days a week to carry out these services. The organisation conducts regular reviews and internal audits of cleaning and laundry services to ensure these are safe and effective. Where improvements can be made these are implemented. The chemical supplier provides ongoing support and information to staff about safe handling of the products in use, and reviews the effectiveness of methods and product use. Current material safety data sheets about each product are located with the chemicals. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The emergency management plan complies with all applicable statutory requirements. It continues to be reviewed and improved to make it simpler and more practical.  The service undertakes regular participation in the health provider response key stakeholder group, its commitment to staff training in emergency preparedness and formalising emergency protocols with another aged care provider to support each other if and when needed. There has been considerable planning and review into ensuring that the best and appropriate products and equipment are stored in the emergency and disaster room. The facility has back up lighting, power, and sufficient food, water and personal supplies to provide for its maximum number of residents and carers in the event of a power outage.  The evacuation scheme is current and external company has attended and observed all six monthly trial fire evacuations. Outcomes and learning from these exercises are documented and used to improve protocols (eg, education posters which describe the different fire alarm tones are displayed in staff areas).  The emergency plans and security systems in the ORA all meet regulation requirements. |
| 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 | The village is heated using both gas and electrical heating. These can be individually controlled in each bedroom and in the communal areas. Maintenance staff ensure the heating systems are running smoothly and that pressure checks are performed. There are functional heaters in each bathroom. The village has sufficient doors and external opening windows for ventilation. All bedrooms have good sized external opening windows which are designed and installed to be secure. The residents and relatives interviewed confirmed that internal temperatures and ventilation are comfortable during summer and winter months. |
| 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 review. The programme is signed off by the general manager. The infection control programme aims to minimise risk of infections to residents, staff, family/whanau and visitors to the facility. The organisation is a member of an external specialist infection control service. The organisation is a member of an infection control organisation which provides education and guidelines for all aspects of infection prevention and control management. Reference and resource material is accessible to the staff.  The infection control portfolio is led by a registered nurse and overseen by management. A job description is available which states clear guidelines for the accountability and responsibilities involved with this role. The Infection Control Nurse (ICN) monitors all infections, uses standardised definitions to identify infections appropriately, and carries out surveillance monitoring of organisms, related to antibiotic use. Monthly records are maintained. Infection control is presented at each staff meeting.  The ICN was not available for interview however, the quality assurance manager (RN) fully supported the programme and had a good understanding of the early detection of suspected infections. Care staff are skilled and ensure they notify the registered nurses of any concerns when caring for residents. The shift handovers are also a forum for reporting incidences of infection. Short term care plans are used, for example for wound care and other infections and fluid balance records are also discussed. There is an infection record in each of the randomly selected resident’s files reviewed.  A process is identified in policy for the prevention of exposing others to infection. Staff interviewed knew when not to come to work and when to return. Signage is used in the facility as required. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Infection control advice can be sought from the GP, microbiologist, the specialist advisory service and from the representatives of the DHB infection prevention and control team if and when required. The GP interviewed is well informed of obligations and reporting systems if needed for notifiable infection outbreaks of disease or illness. There was an outbreak of Norovirus in July 2015 and this was managed appropriately. Records were maintained. Guidelines and a pandemic plan are in place should an incident arise. |
| 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 | An experienced registered nurse has the role of ICN and has only been in this role for a short period of time. The infection control committee meets regularly and reports any issues to the monthly staff meetings. The ICN and the registered nurses are all experienced and are overseen by the management team. External specialist advice is available if and when required through the GP, diagnostic service utilised and the DHB infection control team. An externally contracted specialist infection control advisor also provides educational opportunities for staff to attend. Training is also provided by the DHB. An infection control flip chart is situated in all service areas.  The quality assurance manager, registered nurses and healthcare assistants interviewed each demonstrated good knowledge and interest of infection prevention and control. |
| 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 | The infection control manual has recently been reviewed. The manual is divided into seven sections covering the infection control standards, organisation management of IC programme, policies, procedures, guidelines and work practices, surveillance, monthly continuous quality improvement, annual review, references and appendices used. The objectives of the IC programme are clearly documented.  This IC manual is supported by the IC policies and procedures and the external specialist service`s reference/resource manual which was sighted. Specific infection control areas, such as antibiotic use, methicillin resistant staphylococcus aureus (MRSA) and other antimicrobial screening, wound care management, blood and body spills management, cleaning and disinfectant are covered adequately. Laundry, kitchen and cleaning policies and procedures are developed and implemented specifically for the relevant services provided. Standard precautions are adhered to throughout all areas of service provision.  Observations at the onsite audit identified the implementation of infection prevention and control procedures. Staff demonstrated 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 education is included in the orientation for all newly employed staff and as part of the ongoing annual training timetable 2015 which was reviewed. Infection preventions and control education is provided by the ICN, registered nurses and/or the quality assurance manager. External trainers are contracted as required. Study days are planned and displayed on the staff notice board. Education evidence is available and was sighted on the day of the audit.  The quality assurance manager, registered nurses and healthcare assistants interviewed demonstrated good knowledge of infection prevention and control. Resident education is conducted as required. Hand hygiene is encouraged by all staff and management. |
| 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 | The infection prevention and control surveillance that is undertaken is appropriate to the size and complexity of the service as shown in the infection control programme. All staff are required to take responsibility for surveillance activities as shown in the policy reviewed. An infection form is completed as soon as signs and symptoms have been identified and given to the ICN. Monitoring is described in the infection control plan to describe actions taken to ensure residents` safety.  The quality assurance manager completes the monthly infection surveillance report. Monitoring occurs for all urinary infections (UTIs), eye infections, upper respiratory and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections. Five residents currently have indwelling urinary catheters and one resident has a colostomy. Risks are minimised with good techniques utilised by the GP and staff undertaking procedures for these residents as needed. The monthly analysis of the infections includes comparison with the previous month, reasons for the increase or decrease of infections and actions taken to reduce infections. The analysis includes a summary that can be fed back to staff at the staff meetings. Graphs are available as a visual methodology which staff can relate to and these are displayed for staff on the staff notice board. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service restraint policy meets the standards and the definition of an enabler is congruent with the definition in the standard.  On the days of audit the restraint register listed seven residents using bed rails and/or lap belts. This included one resident using bed rails as an enabler. The resident records contained evidence that assessment for use had been conducted prior to use, alternatives had been tried, approval granted by the restraint committee and valid consent obtained by either the resident or their welfare guardian. There was evidence of ongoing monitoring and review of each restraint intervention. The service has succeeded in safely and incrementally reducing the number of restraints from 12 in January 2015 to seven at the time of audit.  There has been an emphasis on upskilling staff to better understand the requirements of this standard. The coordinator is maintaining a list of staff who have attended education and completed the competency test. There are also prompt cards and posters displayed in staff areas as reminders. Feedback from staff on the new training approach was positive. All new staff are provided with information about the restraint policy, philosophy and approach during their orientation. |
| 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 | Policy and procedures for restraint use and approval are clearly defined in the policy. A RN with extensive experience in aged care is the designated restraint coordinator. The role and responsibilities are described in the coordinator’s position description and include oversight of all restraint in use with support from the restraint committee. The restraint approval committee is comprised of the restraint coordinator, the GM and a GP. The committee convenes as needed to review and consider restraint assessments and make approval. There was clear approval for use of restraint and an individual restraint management plan in each the resident’s records reviewed. |
| 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’s 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. All risks associated with the use of restraints was identified and highlighted. |
| Standard 2.2.3: Safe Restraint Use  Services use restraint safely | FA | The service is aiming to reduce the amount of restraint in use through the purchase of ultra-low beds, alarm mats and perimeter guard rails to prevent injury from rolling out of bed. The records of restraint use show a steady decline in the past six months. The alternatives considered and trialled were documented in the restraint forms and in resident’s restraint management plan. Healthcare assistants and staff are aware of alternatives and seek new ideas. All staff must pass an annual restraint competency test. The restraint register is updated each month and records the resident name, the type of restraint in use, when it was initiated and when it is due for review. |
| Standard 2.2.4: Evaluation  Services evaluate all episodes of restraint. | FA | Documents, including resident care records, and staff interviews confirmed that ongoing restraint use is appropriately evaluated and reviewed every three months by the restraint coordinator. Staff state they try different approaches to reduce restraint use and minimise unwanted behaviour. 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. | FA | The restraint coordinator conducts a comprehensive quality review in November. This yearly review occurs after the GM completes the internal audit of restraint practices. The quality review considers trends in restraint use, compliance with policy and procedures, any adverse events related to restraint use and staff education and competence. There is evidence that the strategies in place to reduce the use of restraint are succeeding. |

# 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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# 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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End of the report.