

Masonic Care Limited - Glenwood Masonic Hospital

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](#).

The specifics of this audit included:

Legal entity:	Masonic Care Limited
Premises audited:	Glenwood Masonic Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 November 2015 End date: 19 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:	42

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Glenwood Masonic Hospital provides rest home and hospital level care for up to 48 residents and is operated by Masonic Care Limited. The service is managed by a facility manager and a clinical nurse leader. The residents and families interviewed spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service contract with the district health board. The audit process included review of policies and procedures, review of resident and staff files, observations and interviews with residents, family, management, staff and a nurse practitioner.

There is one area identified that requires improvement relating to resident documentation.

Consumer rights

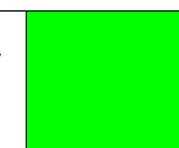
Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

The service has policies and systems in place to ensure that residents' rights are respected, and that residents are free from discrimination and/or abuse and neglect. Staff receive regular training to ensure they respect the independence, personal privacy, individual needs and dignity of residents.

The services provided to residents are of an appropriate standard, and during the audit visits residents were observed to be treated in a pleasant and professional manner. Residents and their families reported their satisfaction with the services provided and of the open communication with staff.

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
---	---	--

Masonic Care Limited is the governing body and is responsible for the service provided at this facility. A strategic business plan and quality and risk management systems are fully implemented at Glenwood Masonic Hospital and documented scope, direction, goals, values, and a mission statement were reviewed. Systems are in place for monitoring the service provided including regular reporting by the facility manager to the chief executive officer.

The facility is managed by an experienced and suitably qualified facility manager. The facility manager is a registered nurse and is supported by a clinical nurse leader/registered nurse. The clinical nurse leader is responsible for the oversight of the clinical service in the facility.

There was evidence that quality improvement data is collected, collated and analysed and reported back to staff. There is an internal audit programme in place and internal audits have been completed. Corrective action plans have been developed to address areas identified as requiring improvement. Graphs of clinical indicators were available for staff to view along with meeting

minutes. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

Policies and procedures on human resources management are followed. Current annual practising certificates for health professionals who require them are on file. An in-service education programme is provided for staff, study days are held twice a year and other training is provided via online learning. Staff are also required to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained.

There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The facility manager and clinical nurse leader are rostered on call after hours. Care staff reported there were adequate staff available and that they are able to get through their work. Residents and families reported there were enough staff on duty to provide adequate care.

Well-established systems and processes are in place to ensure the security and privacy of resident-related information.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
--	--	--

Registered nurses are on duty 24 hours each day, with either the clinical nurse leader or facility manager on call after hours. There are well-established processes in place to guide continuity of care, such as the updating of resident progress notes each shift, and written and verbal handover of information between shifts.

Care plans are individualised, based on a comprehensive and integrated range of clinical information and include input from residents and families. Residents' progress towards achieving identified goals is evaluated on a regular basis, and more frequently when residents' needs change. The development of the initial assessment/care plan within a timely manner is an area for improvement.

The kitchen was well organised and maintained in a clean and hygienic manner. Staff have the appropriate food safety qualifications. There was a systematic and comprehensive approach to ensuring that all aspects of food services were well managed, and that resident's individual needs were being met.

Diversional therapy staff manage the residents' activity programme, which offers residents a variety of individual and group activities. Residents are encouraged to maintain their links with the community and a facility van is available for resident outings. Resident meetings are held monthly.

All aspects of medication meet legislative and best practice requirements. Medications are administered by registered and enrolled nurses who have demonstrated their competency in relation to medicines management.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
--	--	--

All building and plant comply with legislation with a current building warrant of fitness displayed. A preventative and reactive maintenance programme includes equipment and electrical checks. The environment is appropriate to the needs of the residents and all bedrooms have been approved as dual purpose rooms, for use by residents who require either rest home or hospital level care.

Residents' rooms are large and allow for care to be easily provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. A call bell system allows residents to access help when needed and residents stated that these are answered in a timely manner.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
---	--	--

The service has documented policies and procedures for restraint minimisation and safe practice. Systems are in place that ensures assessment of residents is undertaken prior to restraint or enabler use. The restraint coordinator confirmed that enabler use is voluntary and the least restrictive option.

There are residents using restraint and enablers. Staff education includes all required aspects of restraint and enabler use along with alternatives to restraint and behavioural management. Staff demonstrated a sound knowledge and understanding of all restraint and enabler processes.

Infection prevention and control

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

Infection prevention and control is well managed by the service. The infection control coordinator has received relevant training and is supported in the role by the facility manager and the infection control committee. There is regular infection control training for staff, who have access to an appropriate range of personal protective equipment.

Infection surveillance is managed comprehensively. The results of the monthly infection surveillance reports are reported to management and staff, with data benchmarked externally. Two quality initiatives have recently been implemented in response to infection surveillance findings. These initiatives have included staff education and practice changes. The evaluation of these projects is currently underway.

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	0	1	0	0
Criteria	0	100	0	0	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The orientation of all new staff includes education related to the Health and Disability Commissioner’s Code of Health and Disability Services Consumer’s Rights (the Code). On interview staff demonstrated a clear understanding of the Code and were able to explain how this would be incorporated into their everyday practice. The clinical nurse leader advised that during the orientation process staff must also confirm in writing that they are familiar with the contents of the Residents’ Rights policy. Ongoing education on resident rights is available to staff through an online training programme.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Residents and family members staff interviewed stated they were able to make informed choices, and that their consent was obtained and respected.</p> <p>Each resident, and/or their EPOA, completes a comprehensive consent form at the time of admission. Consent is reviewed on an as-required basis, such as when a resident’s needs change, or additional medical/surgical treatment is required. Completed consent forms were seen in all residents’ records reviewed. The admission documentation completed by each new resident and/or their family member identified inclusions and exclusions in service.</p> <p>At the time of the audit visit there were no residents with advance directives, although the clinical</p>

		<p>nurse leader advised these would be respected.</p> <p>All resident records reviewed contained a completed resuscitation authorisation form. This form is reviewed annually and if a resident's conditions changes. The service is currently reviewing the format of its resuscitation form, so that more information relating to the basis for the resuscitation decision can be documented.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>At the time of admission to the service residents are given information on the Nationwide Health and Disability Advocacy Service (Advocacy Service) including contact details. Residents and family members confirmed on interview their awareness of the Advocacy Service and how to access this. On interview, staff demonstrated their understanding of the Advocacy Service, including contact details.</p> <p>The service has recently appointed an independent advocate, who represents residents at the monthly residents' meetings, and is available to support residents as required. This advocate visits the facility at least weekly, and has free access to residents.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>There are no restrictions to visiting hours at the facility and visitors are encouraged. Family members interviewed stated they felt welcome when they came to visit.</p> <p>If residents are well enough, they are supported to maintain their community interests, and to visit with families including overnight stays. The service has a mobility van which is used for resident outings at least weekly. The service's community car is also available to transport residents to health-related services outside of the facility.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The facility manager is responsible for complaints and there are appropriate systems in place to manage the complaints processes. A complaints register is maintained that included 15 complaints for 2015 and these were managed appropriately.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code. Systems are in place to ensure residents and their family are advised on entry to the facility of the complaint processes and the Code. Residents and families demonstrated an understanding and awareness of these processes. The complaints process was readily accessible and/or displayed. Review of quality and staff meeting minutes provided evidence of reporting of any complaints to staff. Care staff confirmed this information is reported to them via the staff meetings.</p>

		<p>There is an ongoing investigation from 2014 being carried out by the Health and Disability Commissioner (HDC) which involved the Coroner and Police. There has also been an investigation by the DHB and documentation indicates this is now closed. There have been no investigations by the Ministry of Health or the Accident Compensation Corporation (ACC) since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>All residents and family members interviewed confirmed their understanding of residents' rights and that they had been given information about the Advocacy Service. As part of the admission process residents are provided with a pamphlet about the Code. This is discussed with them by a registered nurse at that time, and followed by discussions/clarifications on an as-required basis.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Systems and processes are in place to maintain the personal, auditory, visual and physical privacy of residents. All residents have a private room except for one married couple who share a room. During the audit visit, staff were observed to interact with residents in a pleasant, professional manner. Staff were also noted to knock on residents' doors before entering, addressing residents by their preferred name and ensuring that residents' privacy was maintained during personal cares. Strategies are also in place to ensure privacy when residents use shared bathroom facilities. Residents and families interviewed confirmed that residents were treated respectfully at all times.</p> <p>The privacy of resident information is maintained. All residents' clinical files are held in the nurses' station; personal information in administration files is password protected; archived records for current records are stored securely. The privacy of resident information is maintained during the verbal handover from one shift to the next.</p> <p>A review of residents' records included evidence that care plans were developed in consultation with the resident and/or their family. Plans were individualised, and included interventions to ensure that the resident's cultural, religious and social needs, values and beliefs were upheld. Care plans also recorded resident's functional abilities, and strategies to maintain their independence.</p> <p>The service's code of conduct, and the therapeutic boundaries policy guide staff in keeping residents safe. The service's policy related to abuse and neglect was well understood by those staff interviewed. They were able to provide examples of what would constitute abuse and neglect and the actions they would take if they suspected this. All staff undergo a police check as part of the employment process and staff human resource records confirmed those checks had</p>

		been completed and that referee checks had also been completed. Staff education related to abuse and neglect was completed within the previous twelve months.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>At the time of the audit visit there were no residents who identified as Maori, although there was a comprehensive Maori Health Plan in place to guide care for Maori when required. This includes a cultural assessment guide, common Maori terms, and Maori health framework. The service's Tikanga Best Practice guidelines are also readily available to staff. The clinical nurse leader advised that the service presently employs three staff who identify as Maori and there are well-established relationships with local Maori leaders who are available to provide cultural support. Families are supported to be involved in caring for their family member as they wish, and facilities are available for when larger family groups wish to be in attendance.</p> <p>Cultural beliefs and related requirements are incorporated into the resident's admission profile, which then informs the relevant section of the care plan. The clinical nurse leader advised that deceased residents' rooms are always blessed by a designated staff member prior to the next resident being admitted. A kuia recently blessed the whole building following a number of residents' deaths.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents' personal preferences and special requirements were included in all care plans reviewed, with appropriate interventions included to ensure these were met. There was also evidence in those care plans of the resident and/or their family being involved in their development and ongoing evaluation.</p> <p>All residents and family members advised on interview they had been consulted about the resident's individual ethnic, cultural, spiritual values and beliefs, both at the time of admission and on an ongoing basis. They also confirmed that these values and beliefs were respected.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>New staff orientation includes information on ensuring residents are free from any form of discrimination. Staff members interviewed were clear about what constitute inappropriate behaviour and what action should be taken should this be suspected. All residents and family members interviewed stated that residents were free from any type of discrimination or exploitation.</p> <p>A nurse practitioner confirmed their satisfaction with the standards of service provision and confidence that residents are not discriminated against in any manner. The house doctor was on</p>

		leave during the audit visit and was not available for interview.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	<p>The clinical nurse leader advised that the service utilises information from a range of sources to ensure that appropriate standards of service delivery are maintained. This includes consulting with a range of specialist staff from the Wairarapa District Health Board, including speech-language therapists, physicians, psychogeriatrician, occupational therapists and dietitian. The service is also able to consult with Kahu Kura Palliative Care Services and the doctor and/or nurse practitioners visit weekly.</p> <p>Best practice information is also sourced from nursing journals and the internet. A range of clinical policies reflecting best practice are also available to guide practice related to wound care, diabetes management, pain management.</p> <p>On interview, a nurse practitioner confirmed satisfaction with the standard of care provided to residents.</p>
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	<p>The resident records reviewed demonstrated evidence of open disclosure and effective communication with residents/families. Communication was documented in family communication sheets, on the accident/incident form and in the residents' progress notes. Evidence was signed of resident/family input into the care planning process. All family members interviewed stated they were informed in a timely manner about any changes to the resident's status.</p> <p>The clinical nurse leader advised that the service has a list of resource people who are available as translators, together with a number of staff. Interpreter services can also be accessed from the Wairarapa DHB when required.</p>
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	<p>Masonic Care Limited is governed by a board of trustees who meet 11 times throughout the year. The chief executive officer (CEO) advised they present a report to the board which includes a wide range of subjects including facility performance, care reporting, HDC investigations and sector issues.</p> <p>There are established systems in place which define the scope, direction and goals of the organisation, as well as the monitoring and reporting processes against these systems.</p> <p>The service philosophy is in an understandable form and is available to residents and their family</p>

		<p>/ representative and other services involved in referring people to the service.</p> <p>The chief executive officer and facility manager stated they meet on site at least monthly and are in phone contact two to three times per week.</p> <p>The facility manager, who is a registered nurse, has 20 years' experience including facility manager positions in age care facilities and home support and community experience. The facility manager has been in this position since June 2015. The facility manager is supported by a clinical nurse leader who is a registered nurse and was appointed to their current position in August 2015. Prior to this appointment the clinical nurse leader was an RN for 10 years in another aged care facility. The clinical nurse leader is responsible for oversight of clinical care. Interview of the facility manager and clinical nurse leader and review of their personal files evidenced they have undertaken education in relevant areas.</p> <p>Glenwood Masonic Hospital is certified to provide hospital and rest home level care. On the first day of this audit there were 21 hospital level care residents and 21 rest home level care residents. This includes four residents under the 'Occupational Right to Occupy Agreement' (ORA).</p> <p>Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</p> <p>The service has contracts with the DHB to provide Aged Related Residential Care, 'Health Recovery Programme', 'Long Term Support – Chronic Health Conditions' 'Residential Care for Palliative care Patients' and 'Respite Services'.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the facility manager, the clinical nurse leader deputises for the facility manager. When the clinical nurse leader is absent, the facility manager is responsible for clinical oversight. The facility manager and clinical nurse leader confirmed their responsibility and authority for these roles.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</p>	<p>A risk management plan was reviewed and this is used to guide the quality programme. Purpose, goals and objectives and scope are included in the plan.</p> <p>The resident satisfaction survey was completed in 2015 and results indicated that residents and</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>families were satisfied to very satisfied with the services provided.</p> <p>Completed audits for 2015, clinical indicators and quality improvement data was recorded on various registers and forms and were reviewed. Review of the quality improvement data provided evidence the data was being collected, collated, and analysed to identify trends and corrective actions are developed, implemented and evaluated. Quality data is benchmarked by an external agency.</p> <p>Management, quality, infection control, health and safety, restraint, staff and RN/EN meetings are held monthly and minutes were reviewed. The facility manager, clinical nurse leader and quality coordinator stated quality data is discussed at the various meetings. There was documented evidence of reporting on various clinical indicators and quality and risk issues in these meetings. Staff reported during interview that copies of meeting minutes and graphs are available for them to review in the handover room. This was confirmed during observations during the audit.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and reference legislative requirements. Policies / procedures are reviewed and are current. Staff confirmed during interview that they are advised of updated policies and they confirmed the policies and procedures provide appropriate guidance for the service delivery.</p> <p>A health and safety manual is available. Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>Staff document adverse events on an accident/incident form and these are reviewed by a registered nurse before review and sign off. Adverse events are collated by the facility manager at the end of each month, graphed and reported at the monthly quality and staff meetings.</p> <p>There is an open disclosure policy. Residents' documentation reviewed provided evidence of communication with families/next-of-kin/enduring power of attorney (EPOA) following adverse events involving the resident, or any change in the resident's condition.</p> <p>Staff confirmed they are made aware of their notification responsibilities through job descriptions and policies and procedures, which is confirmed via review of documentation. Policy and procedures comply with essential notification reporting (eg, health and safety, human resources, infection control). The facility manager advised there have been no notifications of significant events made to the Ministry of Health since the previous audit.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>There are policies and procedures on human resources management. Annual practising certificates for all health professionals who require them were current. The skills and knowledge required for each position within the service was documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed along with employment agreements, confidentiality statements, professional boundaries guidelines and acceptable behaviour in the workforce. Individual records of education were maintained for each staff member and were reviewed. Staff files evidenced reference checking and police vetting have been undertaken prior to employment.</p> <p>The community care manager and the facility manager are responsible for oversight of the in-service education programme. The education programmes for 2015 was reviewed and evidenced education is provided via two in-service study days per year, online training and external education. All RNs responsible for medication management have current medication competencies and all clinical staff have current restraint competencies.</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme. The clinical nurse leader and an enrolled nurse are assessors for the programme.</p> <p>An orientation/induction programme is available and all new staff are required to complete this within three months of employment. Staff performance is reviewed at the end of the orientation, goals are set and a performance appraisal is completed annually thereafter. Orientation for staff covers the essential components of the service provided. Staff confirmed they have completed an orientation. Care staff also confirmed their attendance at on-going in-service education and that their performance appraisals are current.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery that is based on best practice. The minimum number of staff is provided during the night shift and consists of one registered nurse and two health care assistants. The facility manager and clinical nurse leader are rostered on-call after hours. Care staff interviewed reported there were adequate staff available and that they were able to complete the work allocated to them. Residents and family interviewed reported there was enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover was provided.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>The resident's unique identifier was included in all components of their records. Clinical records were well-organised and included information such as medical notes, reports from other health professionals and laboratory results.</p> <p>Resident-related information is kept in both hard-copy and electronic files. These files were maintained securely. Electronic files were password protected and can only be accessed by designated staff. Hard copy information is kept in the nurses' station. Archived material was also kept securely but was easily retrievable.</p> <p>Residents' progress notes were completed every shift, and the name/designation of the staff member making these entries was legible. Progress notes detailed resident response to service provision and progress towards identified goals.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>The clinical nurse leader outlined the processes associated with service entry. Prospective residents are provided with detailed information about the service. They are also advised they can only be admitted when their level of required care has been assessed and confirmed by the Needs Assessment and Service Coordination Service (FOCUS).</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them as part of that process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The organisation uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. When a resident is transferred the clinical nurse leader advised that a copy of their care plan, medication chart, advanced directive, resuscitation status, most recent progress notes, and a transfer form go with the resident. Examples were sighted of the yellow envelopes being returned to the facility following residents being discharged from acute care services. All residents' clinical record folders reviewed contained a transfer form ready for completion for emergency transfer situations.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>All aspects of medication management are consistent with legislative requirements and safe practice guidelines.</p> <p>An observation of a medication round confirmed that medications were administered in a safe and appropriate manner. Registered and enrolled nurses administer all medications. Records were sighted that all these staff have been assessed as competent in medication administration.</p>

		<p>Sixteen medication charts were reviewed. Medications had been charted appropriately, resident allergy status was documented, and medication administration records were complete.</p> <p>Medications are supplied to the facility using the blister pack system. The clinical nurse leader and a registered nurse advised that these packs are checked against the medication chart by a RN on arrival to the service. All medications in the medication trolleys and stock cupboards were within current use date. The date of first use of eye drops was recorded on those products currently in use. Surplus and expired medication is returned to the pharmacy. Stocktakes of all controlled medication is undertaken weekly. Records of the weekly medication fridge temperature checks were sighted.</p> <p>The service does not use medication standing orders. There are currently no residents who are self-medicating, but processes and systems are in place should this be required.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>All aspects of food procurement, preparation and delivery comply with legislative requirements.</p> <p>The support services manager, a qualified chef, manages food services for the facility. All kitchen staff have completed NZQA Unit Standard 167 (food safety). Staff are also undertaking additional training modules through an external training provider.</p> <p>On inspection the kitchen was well maintained, clean and tidy. The kitchen operates a local council-approved food control programme (sighted). Food storage complied with all current legislation. Food in the fridge and freezers was dated and covered. Cleaning schedules were sighted, together with records of fridge and freezer temperature monitoring.</p> <p>The kitchen catered for a range of nutritional requirements, including diabetic, vegetarian, gluten-free and soft diets. A four weekly menu, with summer and winter options, was last reviewed by a qualified dietician on 2 September 2015. Specialised crockery, such as lip plate and feeding cups, are available. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs noted and actioned.</p> <p>There is an effective and systematic approach to ensuring that residents' nutrition and fluid intake is carefully monitored, while clinical staff ensure residents are weighed monthly.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the</p>	FA	<p>The clinical nurse leader outlined the processes that would be undertaken if a prospective resident did not meet the entry criteria, or the service did not currently have a vacancy. This included working with the consumer and their family to refer them to FOCUS to support them to find appropriate care/placement.</p>

<p>consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>		
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The clinical nurse leader reported that residents are normally assessed by a registered nurse within 24 hours of admission. Registered nurses are responsible for all assessments and care plan development/evaluation. A short term care plan is developed utilising a range of information provided by the resident/family, the Needs Assessment and Service Coordination assessment, clinical assessments such as falls risk and pressure area risk, together with any other relevant referral information. Refer also to Criterion 1.3.3.3. An interRAI assessment is commenced within three days of admission and all resident records reviewed contained a current interRAI assessment. The clinical nurse leader advised that six nursing staff have completed interRAI training, with all but one newly-admitted resident admitted now on the interRAI system.</p> <p>Within three weeks of admission a long term care plan is developed, which is informed by a comprehensive range of clinical assessments, including oral health, nutritional falls risk, pressure area risk, continence and pain assessment, plus the interRAI assessment findings. This was confirmed in all residents' records reviewed, which also included documented evidence of resident/family input into the assessment and care plan development process.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>All residents have an individualised care plan which provides guidance for care delivery staff to support the resident's identified needs. In the residents' records reviewed the care plans reflected the support needs of residents, the outcomes of the integrated assessment process, and the input of residents/families. Residents and families interviewed confirmed their participation in the development of care plans and their ongoing evaluation and review. The clinical nurse leader reported that a project is shortly to commence to review the alignment of the interRAI assessment findings and the current care plan format.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff and well-established processes are in place to ensure continuity of care.</p> <p>Residents' records reviewed included evidence of regular, timely and comprehensive ongoing assessment of needs which then informed the provision of care services. Three visiting health professionals interviewed during the audit confirmed their satisfaction with the standard of care provided to residents.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>A registered diversional therapist (DT) with twelve years' experience in the role coordinates the residents' activity programme, supported by a second staff member who is currently completing the DT training, and two casual staff. The DT is a member of the local DT group.</p> <p>The DT advised that an assessment of residents' previous and current interests is undertaken within a week of their admission. They also confirmed that the current assessment/activity plan format will be reviewed as part of the planned project relating to care plans. This will help promote the explicit documentation of resident activity goals and planned interventions.</p> <p>Individual activity plans are completed within three weeks of the resident being admitted, and evaluated three monthly, which was confirmed in resident files reviewed. These plans help informed the development of the monthly activities programme. Each week residents are given an individual copy of the programme for that week, with copies of the monthly planner also available for residents to review.</p> <p>Activities planned for the month of the audit visit included news/quizzes, games, exercises, Tai Chi, crosswords, board games, outings in the facility van, crafts, church services, cooking and movies. Activities are provided both in group and one-on-one basis. The DT is also responsible for facilitating the monthly residents' meetings (minutes sighted) and the three-monthly residents' newsletter.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Registered nurses are responsible for the evaluation of resident progress towards previously identified goals. Evaluations were completed three-monthly for hospital-level residents and six-monthly for rest home residents, or more frequently if clinically indicated. Clinical reassessments are also undertaken as part of the evaluation process, as confirmed in all resident records reviewed. Care plans were updated when residents' progress was different from expected. Short term care plans were also developed as required, and reviewed in a timely manner.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or</p>	<p>FA</p>	<p>If the need for other health services is identified, a referral is sent to seek specialist provider assistance, with copies of referrals sighted in several of the resident records reviewed. Support is available to transport and accompany residents to health-related visits outside of the facility, such as hospital appointments or visits to the dentist, if there is no family member available to accompany them. Families interviewed confirmed they were kept informed about referral processes and the outcomes of these referrals. The right of residents to access other health</p>

provided to meet consumer choice/needs.		and/or disability providers is maintained.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes are in place for the management of waste and hazardous substances, including specific labelling requirements. Material safety data sheets provided by the chemical representative are available and accessible for staff. Education on chemical safety has been provided as part of the staff in-service education programme. Staff confirmed this.</p> <p>Observations provided evidence that hazardous substances were correctly labelled, the containers were appropriate for the contents, including container type, strength and type of lid/opening. Protective clothing and equipment that is appropriate to the risks associated with waste or hazardous substances being handled was provided and being used by staff. For example, gloves, aprons masks and visors.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The facility is purpose built with wide passageways and good storage space for mobility aids. The six occupational right agreement units are within the facility and there are three units incorporated into two of the wings.</p> <p>A current building warrant of fitness is displayed that expires on the 27 July 2016. Review of documentation provided evidence there are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme in place and buildings, plant and equipment are maintained to a high standard. Documentation reviewed, the maintenance person interviewed and observation confirmed this. The testing and tagging of equipment and calibration of biomedical equipment is current.</p> <p>There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside.</p> <p>Care staff confirmed they have access to appropriate equipment, equipment is checked before use and they are competent to use it.</p> <p>Residents interviewed confirmed they know the processes they should follow if any repairs/maintenance is required and that requests are appropriately actioned. Residents interviewed confirmed they are able to move freely around the facility and that the accommodation meets their needs.</p>

<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There is a mix of bedrooms with their own full ensuites, full ensuites shared between two bedrooms and the rest comprised of three bedrooms sharing a bathroom. There are adequate numbers of toilets throughout the facility including toilets for visitors. Residents and families interviewed reported that there were sufficient toilets and showers that are easy to access.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Bedrooms are large and there is lots of personal space provided to allow residents and staff to move around within the bedrooms safely. The majority of bedrooms are single accommodation and double bedrooms are currently used as single accommodation. Residents interviewed all spoke positively about their rooms. Rooms are personalized with furnishings, photos and other personal adornments.</p> <p>There is room to store mobility aids such as mobility scooters and wheel chairs.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>There are many areas for residents to frequent for activities, dining and relaxing. Areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. Residents and family confirmed this.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>All laundry is washed on site. The laundry person had good knowledge of the laundry processes. Residents and families reported the laundry was well managed and their clothes are returned in a timely manner.</p> <p>There are dedicated cleaners on site who have received appropriate training. Interview of a cleaner and training records confirmed this. The cleaners have lockable cupboards to store chemicals. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme. Residents and family stated the facility is cleaned to a high standard. Observations during the audit confirmed this.</p>

<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The evacuation plan was approved by the New Zealand Fire Service on the 12 August 2010. An evacuation policy on emergency and security situations is in place. A fire drill takes place six-monthly with a copy sent to the New Zealand Fire Service and was last held on the 27 October 2015. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures.</p> <p>There is always at least one staff member on duty with a current first aid certificate.</p> <p>All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQ's.</p> <p>There are call bells to alert staff. Call system audits are completed on a regular basis and residents and families reported staff responded promptly to call bells.</p> <p>The doors are locked in the evenings. A camera situated at the front entrance enables staff in the nurse's station to identify visitors after hours.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Heating is provided by hot water radiators. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. There is a designated external smoking area. All resident areas are provided with natural light.</p> <p>Family and residents interviewed confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>A registered nurse is the designated infection control coordinator. Infection control matters, including surveillance results, are reported monthly to the infection control committee and to the facility manager, who in turn reports to the Masonic Trust Board via the CEO. Meeting minutes and monthly reports were sighted. The results of the surveillance programme and any other infection control matters are shared with staff via the regular staff meetings, as confirmed in meeting minutes. The infection control committee meets every second month, and contains representatives from across the service.</p> <p>A comprehensive infection control manual guides infection control practices. The manual</p>

		<p>includes definitions, procedures, guidelines to identify infections, information for all employees related to accidents, spills, needle stick injury prevention, sharps management and single-use items. This manual is reviewed annually, with the last reviewed being undertaken in October 2015. An additional infection control manual, produced by an external provider, is also available as a resource for staff if required.</p> <p>A sign at the main entrance to the facility ask anyone who is or has been unwell not to enter the facility, and reminds visitors about the need for handwashing. Information for staff on how long they must stay away from work if they have been unwell is included in the infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>Personal protective equipment is freely available to staff, who confirmed the availability of this equipment. The service also maintains an appropriate supply of additional equipment in case of an infection outbreak (supplies sighted).</p> <p>The infection control coordinator, a registered nurse, has been in the role since September 2014. He has attended several infection control management training courses, as confirmed in training records. He advised that he is able to access additional support/information from a range of resources. These include an infection control manual produced by an external provider; the infection control nurse at the Wairarapa District Health Board, the Public Health unit, plus online resources and articles.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>A comprehensive policy/procedure manual guides infection prevention and control practices. These comply with relevant legislation and current accepted good practices. The manual is reviewed annually, with the last review being undertaken in October 2015.</p> <p>Housekeeping and kitchen staff were observed to be compliant with infection control practices. Care delivery staff were observed using hand-sanitisers on a regular basis and wearing disposable aprons and gloves as appropriate.</p>
<p>Standard 3.4: Education</p>	FA	<p>The infection control coordinator advised that he personally meets with all new staff as part of their orientation programme. There is annual staff training on infection control, as confirmed in</p>

<p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>		<p>staff training records and the annual education plan. Examples were sighted of the contents of recent education sessions. Additional staff education is also provided on an as-required basis. An audit of staff handwashing competency is also undertaken annually, and results discussed with staff.</p> <p>Education with residents is generally on a one-to-one basis, although there are occasional updates in the facility newsletter which is distributed to all residents. This may include reminders about handwashing or the need for an increased fluid intake in warmer weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance for infection is comprehensively and systematically managed by the service. A monthly surveillance is undertaken by the Infection Control Coordinator related to respiratory, skin, soft tissues, urinary tract, gastrointestinal and multidrug resistant infections. A quality initiative was recently completed to ensure that this data was being fully captured through the development of new reporting format.</p> <p>Surveillance data is collated monthly, and entered into a spreadsheet. Results are trended cross the previous twelve months. Graphs of the results are displayed in the staff handover room. Surveillance data is also entered into an external benchmarking service. Comparisons of surveillance results are also undertaken at the three-monthly meetings of Masonic Trust facilities.</p> <p>The Infection Control Coordinator develops the monthly surveillance record. Graphs are produced that demonstrate rest home and hospital trends across the facility for the current year. Results are also benchmarked with an external benchmarking organisation. The monthly surveillance results are reported to the facility manager, the infection control meeting, registered nurses' meeting and staff meetings. This was confirmed in meeting minutes.</p> <p>Two quality improvement initiatives are currently underway arising from infection surveillance, one related to fungal nail infections and the other to an increase in eye infections. Both these initiatives have involved an analysis of the data, consultation with staff, the development of a project plan, and the implementation of specific interventions, including staff education, to address areas where improvement is sought.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Documented systems are in place to ensure the use of restraint is actively minimised. There were 12 residents using restraint and five residents using an enabler during the audit. The restraint coordinator who is a RN reported a multidisciplinary review of all restraint is conducted three monthly. In-service education relating to restraint and challenging behaviour has been</p>

		provided to all staff. Restraint usage is an agenda item for the management, quality staff and RN/ EN meetings. Care staff demonstrated good knowledge of restraint and enabler processes. Residents' files evidenced completed documentation relating to restraint and enabler use.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>Systems are in place for determining the restraint approval processes. The restraint coordinator and staff interviewed and the residents' files evidenced responsibilities were identified and known. The residents' files evidenced residents and /or family input into the restraint approval processes. There was a documented, formal process for the approval of specific restraint processes at the policy/procedure level. The approval group meets every two months and discussion includes education and competencies, equipment, and the use of restraint.</p> <p>Care staff interviewed were aware of the restraint co-ordinator's responsibilities. Policy/procedures define approved restraints and alternatives to restraint. There were policies relating to strategies to minimise use of restraint and management of disturbed behaviour in accordance with the requirements of the Service Agreement. The orientation/induction programme includes overview of restraint policies/procedures.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Systems are in place that ensure assessments of residents are undertaken prior to restraint usage being implemented. The residents' files demonstrated restraint assessment and risk processes were being followed. The policies related to strategies to minimise use of restraint and management of challenging behaviours.</p> <p>The residents' files reviewed evidenced restraint assessment risks were documented and evaluated on a regular basis and included resident and/or family input. The multidisciplinary reviews evidenced restraint assessment risks were reviewed. Clinical staff interviewed demonstrated a sound knowledge concerning restraint procedures.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>Appropriate systems ensure the service is using restraint safely. The restraint policies and procedures identified risk processes that are to be followed when a resident is being restrained. The residents' files evidenced evaluations, review of restraint goals and interventions and were current.</p> <p>The residents' files demonstrated appropriate alternative interventions were implemented and de-escalation attempted prior to initiating restraint. The restraint consents by resident and/or family were current. The restraint register was current and provides sufficient information.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>The restraint evaluation processes are documented in the restraint minimisation and safe practice policy. The residents' files evidenced each episode of restraint was monitored and evaluated based on the risk of the restraint used. The resident's care plan evaluations and multidisciplinary meetings were current and completed every three months. Restraint meetings minutes were reviewed and are held two monthly. The clinical nurse leader and RNs are responsible for evaluating restraint use and this was confirmed during interview.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Restraint reviews were completed at least three monthly. The outcome of the reviews were documented and reported on, as well as being discussed at meetings. Policies and procedures included monitoring and quality review processes. The last restraint audit was completed on the 10 June 2015.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA</p> <p>Moderate</p>	<p>The development of long-term nursing care plans, and the evaluation/review of these plans was completed within required time frames. Residents were also medically-admitted in a timely manner, and medically reviewed at least three monthly and more often if clinically indicated.</p> <p>The clinical records of five residents admitted to the service within the past twelve months were reviewed. No initial assessment and care (ICA) plan could be located for one of those residents; two ICA's were undated, while a further two ICAs had not been developed within the required 24-hour timeframe. The long-term service delivery plans for each resident was developed within three weeks of admission.</p>	<p>Initial assessments/care plans are not developed within required timeframes.</p>	<p>Initial assessments/care plans are developed within twenty-four hours of a resident being admitted to the service.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.